



C.H.A.I.N. REPORT

Tri-County CHAIN

Report 2002-2

Health Status and Health Service Utilization

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Research Association of New York,
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and the NY Health & Human Services
HIV Planning Council

Originally submitted Nov 13, 2002
Final revision submitted Apr 1, 2003
HRSA Grant # H89 HA 0015-11

ACKNOWLEDGMENTS

A Technical Review Team (TRT) provides oversight for the CHAIN Project. In addition to Peter Messeri, PhD and Angela Aidala, PhD, both of Columbia University’s Mailman School of Public Health, TRT members include Mary Ann Chiasson, DrPH, MHRA (chair); JoAnn Hilger, NYCDOHMH; Jeanne Kalinoski, HIV Planning Council; Julie Lehane, PhD, Westchester County DOH; Jennifer Nelson, MHRA, Richard Peterson, Mayor’s Office of AIDS Planning Coordination; and Tom Sentell, PWA Advisory Group. Additionally, the Tri-County CHAIN project regularly consults with Tom Petro, Jan Carl Park, Julie Lehane, Renee O’Rourke, and Basil Reyes of the Westchester Department of Health.

We are particularly grateful to all the participants in the Tri-County CHAIN Project, who share their time and their experiences with us. We take their trust in us seriously, and hope that our project serves to amplify the voice of the HIV-positive community in Putnam, Rockland, and Westchester counties.

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This research was made possible by grant number H89 HA 0015-11 from the US Health Resources and Services Administration (HRSA) HIV/AIDS Bureau. The CHAIN study is supported by the HIV Health and Human Services Planning Council of New York under a Title I grant of the Ryan White Comprehensive AIDS Resource Emergency Act of 1990 through the New York City Department of Health. It is conducted under the auspices of the Medical and Health Research Association of New York City, Inc, and in Tri-County under the Westchester Department of Health. Its contents are solely the responsibility of the researchers and do not necessarily represent the official views of the U.S. Health Resources and Services Administration; the City of New York; Putnam, Rockland, or Westchester counties; or the Medical and Health Research Association of New York.

Introduction

Much of the CHAIN questionnaire is devoted to self-reported health status, health service utilization, satisfaction with health services, and usage of HIV medications. This report examines several of these issues, and explores whether there are group differences in people's perceived health and service utilization, as well as whether there are differences between the Tri-County CHAIN cohort and the New York City CHAIN cohort. For several of these analyses, the Tri-County cohort was restricted to those individuals diagnosed with HIV prior to 1998, which allows for a relatively similar group when compared with the New York City cohort.

These sets of tables should provide a starting point for future analyses, by describing some of the practices and experiences of HIV+ adults in the Tri-County region and illuminating subgroup differences.

Key Findings

Health Status

The CHAIN questionnaire asks respondents to report on their health using broad questions (how is your health, how is it compared to six months ago, how is your memory, etc.) as well as targeted questions regarding CD4 and viral load levels, recent opportunistic infections, and a series of questions related to HIV medication. One of the central components of this self-reported health status is a 36-item scale derived from the nationally recognized Medical Outcomes Study. This scale involves a series of questions pertaining to an individual's physical and mental health, and allows researchers to arrive at a score (from 0 to 100) that may be compared to other groups in the US population. Among the measures most commonly used in CHAIN reports has been two summary scores, known as the Physical Component Summary score (PCS) and the Mental Component Summary score (MCS). Both of these scores provide a reasonably valid measure of one's physical and mental health.

- As in the NYC CHAIN cohort, Latinos are twice as likely as black respondents to report lower scores on the mental health component summary score (MCS), and significantly less likely than white respondents as well, suggesting a greater objective need for mental health services. Black respondents tend to report the highest mental health scores, although white respondents are the most likely to report that they are in "excellent or very good" health. Overall, a larger proportion of Tri-County respondents, 33%, reported low mental health scores than did the most recent NYC cohort, 24% [see Table 1].
- Other group differences on self-reported health status are that men who have sex with men are less likely to report poor physical or mental health scores than are problem drug users (who report using cocaine, crack, or heroin or who have a drinking problem) [see Table 2].

- On average, 12% of the respondents did not know their t-cell (CD4) count. This is fairly high when compared to the New York City cohort, all of whom knew their t-cell count [see Table 1]. Among racial/ethnic subgroups, 15% of black respondents were unaware of their t-cell count, compared with 6% of white respondents and 9% of Latino respondents. This may suggest a lack of understanding about one's clinical care, inadequate provider-client communication, insufficient health education material, recency of HIV diagnosis or entry in to medical care, or other factors associated with the medical care system.

Health Service Utilization

- Rates of recent emergency room use and in-patient use are relatively similar across Tri-County subgroups [see Table 3]. White respondents are two to three times more likely to report having private insurance than either black or Latino respondents. Overall, 67% of the cohort reports Medicaid as their primary insurance compared with 83% of the latest round of NYC CHAIN respondents.
- Approximately one-third of white respondents are "long-term survivors," having been diagnosed with HIV or AIDS in the 1980's, compared with 19% of black and 21% of Latino respondents [see Table 5]. Whites are similarly more likely to have had an AIDS diagnosis and also more likely to be on Highly Active Antiretroviral Therapy (HAART) medications.

HIV Medications, Adherence, and Drug Holidays

- Approximately three-quarters of the respondents report being on antiretroviral medications, with 28% reporting non-HAART and 46% reporting HAART [see Table 6].
- There are subgroup differences evident in self-reported adherence patterns – men who have sex with men are far more likely to report adherence (87%) to their HIV medications than are problem drug users (54%), MSM/PDU (53%) or heterosexual respondents (65%).
- Tri-County respondents who have ever been diagnosed with AIDS are significantly less likely than New York City AIDS-diagnosed respondents to be on HAART, particularly those individuals who live in Westchester or Putnam counties [see Table 7]. This analysis was restricted to individuals who were diagnosed with HIV prior to 1998, so that the Tri-County and NYC groups were reasonably equivalent, and also to allow for sufficient experience with the HIV system of care so that both groups can be considered equally experienced. The finding suggests that HAART uptake may be slower in certain areas in Tri-County than in New York City.

- In considering what factors might be related to these differences in the reported use of HAART, we looked at a number of respondent characteristics that might be associated with use or non-use of HAART [see Table 8]. These factors included demographic characteristics, such as gender, race/ethnicity, income, education, or insurance status, as well as risk characteristics, such as any episode of unstable housing in the prior 6 months or a history of substance abuse. We considered the influence of each of these factors separately, first within Tri-County and then within New York City. Within Tr-County, only race/ethnicity differences were significantly associated with use of HAART, in that white respondents were more likely than black or Latino respondents to report HAART. In New York City, men were more likely to use HAART than women, and former drug users more likely to report HAART than individuals who had never abused drugs.
- We analyzed all these factors together [see Table 9] in order to consider their combined effect. In other words, if the difference in HAART usage between Tri-County and New York City was primarily due to another factor, such as race/ethnicity, or gender, or substance abuse, rather than a geographical location, then those characteristics would be significantly associated with non-HAART usage and geography would not be associated with it. However, considering all these factors simultaneously, individuals who lived in Westchester or Putnam were approximately half as likely as similar individuals in NYC to be on HAART. There were no differences between Rockland residents and the NYC cohort. Black and Latino respondents, regardless as to where they lived, were also approximately half as likely as white respondents to report being on HAART.
- Finally, respondents were asked whether they had taken a “drug holiday” from their HIV medications in the past six months (known in the medical literature as a “structured treatment interruption”). Nearly one-quarter of the cohort reported a recent drug holiday [see Table 10], and among these individuals 70% reported that they had elected to go on a drug holiday on their own, without consulting their medical provider [see Table 11]. Similar rates of self-determined drug holidays were found in New York City.

Table 1. Self-reported Health Status: Sociodemographic Differences (2001-2002)

	WAVE 1	Gender		Race/Ethnicity			NYC, Wave 8
Characteristic ¹		Male	Female	White	Black	Latino	
Total (n)	398	204	194	82	197	110	388
In general, would you say your health is...							
<i>Excellent or very good</i>	33%	33%	33%	48%***	31%	25%	33%
<i>Good</i>	34%	34%	34%	28%	39%	26%	36%
<i>Fair or poor</i>	33%	33%	33%	24%	30%	48%	31%
Compared to six months ago, is your health generally... (n=382)							
<i>Better</i>	39%	40%	38%	38%	43%	32%	35%
<i>Same</i>	44%	43%	45%	46%	43%	45%	51%
<i>Worse</i>	17%	17%	17%	16%	14%	23%	13%
Physical & Mental Health ²							
<i>Low Physical Health Summary Score (<45)</i>	55%	53%	57%	52%	56%	55%	52%
<i>Low Mental Health Summary Score (<37)</i>	33%	26%**	40%	33%***	24%	49%	24%
T-cell count							
<i>>501</i>	33%	29%	37%	37%*	31%	35%	37%
<i>201-500</i>	35%	38%	32%	29%	39%	32%	44%
<i>≤200</i>	20%	23%	18%	28%	15%	25%	19%
<i>Missing/Don't know</i>	12%	10%	13%	6%	15%	9%	0%
Opportunistic infections (OI)							
<i>OI in past 6 months</i>	36%	35%	36%	37%	34%	39%	35%

¹ Cells represent the percentage of CHAIN participants with each characteristic who report specific clinical outcomes or health status measures, for example, the percentage of men with a t-cell count greater than 500.

² These scores are drawn from a standardized scale, the Short Form 36 of the Medical Outcomes Scale. Mental health scores below 37.0 are highly correlated with clinical psychiatric symptomatology.

* p < .05

** p < .01

*** p < .001

Table 2. Self-reported Health Status: Risk & Geographical Differences

Characteristic ¹	WAVE 1	HIV Risk				Geographical Density		
	Total Cohort	MSM	PDU ²	MSM/PDU	Hetero	Urban Westchstr	Suburbn West / Putnam	Rockland
n	398	62	164	19	153	213	112	73
In general, would you say your health is...								
<i>Excellent or very good</i>	33%	47%	27%	32%	33%	30%	35%	40%
<i>Good</i>	34%	29%	26%	42%	43%	32%	37%	33%
<i>Fair or poor</i>	33%	24%	47%	26%	24%	38%	29%	27%
Compared to six months ago, is your health generally... (n=382)								
<i>Better</i>	39%	42%**	36%	61%	38%	40%	40%	33%
<i>Same</i>	44%	52%	39%	28%	48%	45%	40%	48%
<i>Worse</i>	17%	7%	25%	11%	14%	15%	19%	19%
Physical & Mental Health								
<i>Low Physical Health Summary Score (<45)</i>	55%	40%***	66%	58%	48%	59%	54%	47%
<i>Low Mental Health Summary Score (<37)</i>	33%	29%*	40%	37%	26%	33%	37%	26%
T-cell count								
<i>>501</i>	33%	39%	30%	16%	37%	32%	36%	33%
<i>201-500</i>	35%	37%	36%	53%	31%	37%	31%	36%
<i>≤200</i>	20%	21%	23%	26%	17%	19%	26%	16%
<i>Missing/Don't know</i>	12%	3%	11%	5%	16%	12%	7%	15%
Opportunistic infections (OI)								
<i>OI in past 6 months</i>	36%	35%	35%	37%	36%	40%	31%	30%

¹ Cells represent the percentage of CHAIN participants with each characteristic who report specific clinical outcomes or health status measures, for example, the percentage of men with a t-cell count greater than 500.

² PDU, or problem drug users, are defined as individuals who have ever used cocaine, crack, or heroin three or more times a month, or who have had a drinking problem.

* p < .05

** p < .01

*** p < .001

Table 3. Health Services & Insurance: Sociodemographic Differences

	WAVE 1	Gender		Race/Ethnicity			NYC, Wave 8
Characteristic ¹	Total Cohort	Male	Female	White	Black	Latino	Total Cohort
n	398	204	194	82	197	110	388
Hospital & ER Use							
<i>Any in-patient use</i>	22%	20%	24%	18%	22%	25%	21%
<i>Any ER Use</i>	35%	32%	38%	28%	40%	31%	30%
Insurance							
<i>Private</i>	10%	10%	10%	21%**	6%	8%	9%
<i>Medicaid</i>	67%	64%	70%	55%	74%	64%	83%
<i>Other public insurance</i> ²	22%	25%	19%	24%	19%	26%	8%
None	1%	1%	1%	0%	1%	2%	1%

¹ Cells represent the percentage of CHAIN participants with each characteristic who report specific clinical outcomes or health status measures, for example, the percentage of men who reported any in-patient use in the past six months

² Other public insurance includes Medicaid, ADAP-Plus, and veteran-related insurance

Table 4. Health Services & Insurance: Risk & Geographical Differences

	WAVE 1	HIV Risk				Geographical Density		
Characteristic ¹	Total Cohort	MSM	PDU	MSM/PDU	Hetero	Urban Westchstr	Suburban West / Putnam	Rockland
n	398	62	164	19	153	213	112	73
Hospital & ER Use								
<i>Any in-patient use</i>	22%	23%	26%	16%	19%	23%	18%	26%
<i>Any ER Use</i>	35%	31%	39%	42%	31%	40%	29%	31%
Insurance								
<i>Private</i>	10%	16%**	5%	5%	12%	4%***	15%	18%
<i>Medicaid</i>	67%	55%	80%	63%	58%	78%	56%	51%
<i>Other public insurance</i>	22%	29%	13%	32%	27%	17%	27%	30%
None	1%	0%	1%	0%	2%	1%	2%	1%

¹ Cells represent the percentage of CHAIN participants with each characteristic who report specific clinical outcomes or health status measures, for example, the percentage of urban respondents with Medicaid insurance

* p < .05

** p < .01

*** p < .001

Table 5. Medical Characteristics: Sociodemographic Differences

	WAVE 1	Gender		Race/Ethnicity			NYC, Wave 8
Characteristic ¹	Total Cohort	Male	Female	White	Black	Latino	Total Cohort
n	398	204	194	82	197	110	388
Year of HIV/AIDS Diagnosis							
<i>Prior to 1989</i>	23%	29%*	17%	35%	19%	21%	24%
<i>1990-1995</i>	41%	38%	44%	41%	41%	43%	57%
<i>1996-2002</i>	36%	33%	39%	23%	40%	36%	19%
HIV Stage							
<i>Asymptomatic</i>	22%	20%	24%	12%	24%	25%	8%
<i>Symptomatic HIV</i>	16%	17%	16%	16%	16%	17%	10%
<i>AIDS</i>	62%	63%	60%	72%	60%	57%	82%
HIV Combination Therapy							
<i>None</i>	26%	21%**	32%	21%	25%	31%	29%
<i>Non-HAART</i>	28%	32%	23%	22%	31%	25%	20%
<i>HAART²</i>	46%	47%	45%	57%	43%	44%	51%
Adherence (n on meds)	293	162	131	65	147	76	274
<i>Not completely adherent</i>	37%	30%**	45%	34%	37%	37%	33%
<i>Completely adherent</i>	63%	70%	55%	66%	63%	63%	67%

¹ Cells represent the percentage of CHAIN participants with each characteristic who report specific clinical outcomes or health status measures, for example, the percentage of Latino respondents on HAART

² HAART is Highly Active Antiretroviral Therapy, which are HIV medications prescribed as per NIH guidelines.

* p < .05

** p < .01

*** p < .001

Table 6. Medical Characteristics: Risk & Geographical Differences

	WAVE 1	HIV Risk				Geographical Density		
Characteristic ¹	Total Cohort	MSM	PDU	MSM/ PDU	Hetero	Urban Westchstr	Suburban Westchstr / Putnam	Rockland
n	398	62	164	19	153	213	112	73
Year of HIV Diagnosis								
1978-1989	23%	31%***	29%	47%	11%	22%	26%	22%
1990-1995	41%	37%	44%	37%	41%	43%	39%	40%
1996-2002	36%	32%	27%	16%	48%	35%	35%	38%
HIV Stage								
Asymptomatic	22%	10%*	23%	5%	27%	21%	20%	26%
Symptomatic HIV	16%	24%	13%	16%	18%	16%	15%	19%
AIDS	62%	66%	65%	79%	55%	62%	65%	55%
HIV Combination Therapy								
None	26%	24%	23%	21%	32%	26%	31%	21%
Non-HAART	28%	27%	29%	37%	25%	30%	25%	26%
HAART	46%	48%	48%	42%	43%	45%	44%	53%
Adherent (on meds)	293	47	127	15	104	158	77	58
Not completely adherent	37%	13%***	46%	47%	35%	37%	35%	36%
Completely adherent	63%	87%	54%	53%	65%	63%	65%	64%

¹ Cells represent the percentage of CHAIN participants with each characteristic who report specific clinical outcomes or health status measures, for example, the percentage of MSM (men who have sex with men) who are completely adherent to their HIV medications

* p < .05

** p < .01

*** p < .001

Table 7. Comparative Use of Highly Active Antiretroviral Therapy (HAART) Between Tri-County and New York City Respondents (2001-2002) (*Analysis restricted to individuals who learned their HIV diagnosis in 1998 or earlier, and who have had an AIDS diagnosis at some point in their lives.*)

Geographical Area *	n	number on HAART	percent on HAART
New York City CHAIN cohort	320	161	50% †
Tri-County cohort	209	90	43%
<i>Urban Westchester</i>	115	44	38% *
<i>Suburban Westchester and Putnam County</i>	63	26	41%
<i>Rockland County</i>	31	20	65%

† p < .1

* p < .05

** p < .01

*** p < .001

Table 8. Percent on HAART Among AIDS-Diagnosed Tri-County & NYC Cohorts

	Tri-County Cohort	NYC Cohort
FULL COHORT [denominator TriCo / NYC] (n= 330 / 388)	42%	50%
Gender		
<i>Male (106 / 171)</i>	48%	56% *
<i>Female(103 / 149)</i>	38%	44%
Race/Ethnicity		
<i>White, non-Hispanic (50 / 44)</i>	60% *	59%
<i>Black, non-Hispanic (102 / 181)</i>	36%	50%
<i>Hispanic/Latino (52 / 91)</i>	40%	45%
<i>Other (5 / 4)</i>	40%	75%
Risk characteristic		
<i>MSM (32 / 65)</i>	53%	57%
<i>Problem Drug User (95 / 134)</i>	45%	52%
<i>MSM + Problem Drug User (13 / 30)</i>	38%	47%
<i>Heterosexual and other (69 / 91)</i>	36%	44%
Substance Abuse History		
<i>Never used drugs (58 / 32)</i>	41%	38% †
<i>Former drug user(119 / 224)</i>	45%	54%
<i>Current drug user (32 / 64)</i>	38%	42%
Household Income		
<i>Less than \$10,000 annual household income (101 / 185)</i>	43%	49%
<i>Greater than \$10,000 annual household income (99 / 124)</i>	43%	51%
Education		
<i>Greater than high school (128 / 173)</i>	44%	51%
<i>Less than high school (81 / 147)</i>	42%	49%
Age categories		
<i>20-34 years old (16 / 25)</i>	44%	44%
<i>35-49 years old (138 / 202)</i>	41%	51%
<i>50+ years old (55 / 93)</i>	49%	49%
Insurance		
<i>Private (20 / 25)</i>	55%	48%
<i>Medicaid (158 / 270)</i>	42%	50%
<i>Other Public (29 / 22)</i>	45%	59%
<i>None (2 / 3)</i>	0%	67%

† p < .1

* p < .05

** p < .01

*** p < .001

Table 9. Factors Associated with Use of Highly Active Antiretroviral Therapy (HAART) Among Individuals Diagnosed with HIV before 1998, and Who Have Ever Had an AIDS Diagnosis

Respondent Characteristics	Comparing Tri-County & NYC Cohorts (n=509) Odds of Being on HAART
<i>Living in urban Westchester (versus NYC)</i>	.54 *
<i>Living in suburban Westchester and Putnam (versus NYC)</i>	.57 †
<i>Living in Rockland (versus NYC)</i>	1.2
<i>Women (versus men)</i>	.82
<i>Unstably housed (versus stably housed)</i>	.68
<i>Black (versus non-Black)</i>	.58 *
<i>Latino (versus non-Latino)</i>	.49 **
<i>Former drug users (versus never drug users)</i>	1.5
<i>Current drug users (versus never drug users)</i>	1.1
<i>35-49 year olds (versus 20-35 year olds)</i>	1.0
<i>50+ year olds (versus 20-35 year olds)</i>	1.1
<i>Household annual income <\$10,000</i>	1.1
<i>Less than a high school education</i>	1.0
<i>On Medicaid (versus all other insurance or none)</i>	.87

† p < .1

* p < .05

** p < .01

*** p < .001

Table 10. Client Characteristics Associated with HIV Medication Interruptions, also known as “Drug Holidays” (CHAIN Data, 2001-2002; row percentages)

Client Characteristics	Tri-County		NYC (Wave 8)	
	Total n	% on Drug Holiday	Total n	% on Drug Holiday
TOTAL SAMPLE	381	24%	352	28%
GENDER				
<i>Male</i>	192	23%	181	25%
<i>Female</i>	189	25%	171	30%
RACE/ETHNICITY				
<i>Black, non-Hispanic</i>	189	22%	219	29%
<i>White, non-Hispanic</i>	80	25%	42	24%
<i>Hispanic</i>	104	28%	88	25%
AGE GROUP				
<i>20-34 years old</i>	46	22%	57	32%
<i>35-49 years old</i>	241	24%	236	28%
<i>50+ years old</i>	94	26%	59	22%
DRUG USE				
<i>Never used</i>	129	21%	59	25%
<i>Former user</i>	187	25%	224	23%
<i>Current user</i>	65	31%	69	46%***
GEOGRAPHICAL AREA				
<i>Urban Westchester</i>	206	23%		
<i>Suburban Westchester / Putnam</i>	109	21%		
<i>Rockland</i>	66	33%		

* p < .05

** p < .01

*** p < .001

**Table 11. Client Characteristics Associated with Drug Holiday Decisions
(CHAIN Data, 2001-2002; row percentages)**

Client Characteristics	Decision to take a Drug Holiday: Tri-County					Decision to take a Drug Holiday: New York City				
	Total on Drug Holiday	Solely respondent's		Together w/MD		Total on Drug Holiday	Solely respondent's		Together w/MD	
	n	n	%	n	%	n	n	%	n	%
TOTAL	93	65	70%	25	27%	98	74	76%	23	24%
GENDER										
<i>Male</i>	45	33	73%	11	24%	46	38	84%	7	16%
<i>Female</i>	48	32	67%	14	29%	52	36	69%	16	31%
RACE/ETHNICITY										
<i>Black</i>	42	30	71%	11	26%	64	49	77%	15	23%
<i>White</i>	20	11	55%	9	45%	10	7	78%	2	22%
<i>Hispanic</i>	29	23	79%	4	14%	22	17	77%	5	23%
AGE GROUP										
<i>20-34 years old</i>	10	9	90%	1	10%	18	12	67%	6	33%
<i>35-49 years old</i>	59	38	64%	18	31%	68	51	77%	15	23%
<i>50+ years old</i>	24	18	75%	6	25%	13	11	85%	2	15%
DRUG USE										
<i>Never used</i>	27	21*	78%	5	19%	15	13	87%	2	13%
<i>Former user</i>	46	28	61%	18	39%	52	35	69%	16	31%
<i>Current user</i>	20	16	80%	2	10%	31	26	84%	5	16%
GEOGRAPHICAL AREA										
<i>Urban Westchester</i>	48	37	77%	8	17%					
<i>Suburban Westchstr /Putnam</i>	23	15	65%	8	35%					
<i>Rockland</i>	22	13	59%	9	41%					

* p < .05

** p < .01

*** p < .001

Appendix: DATA & METHODOLOGY

Background

The purpose of the Tri-County CHAIN Study is to assess the impact of the full continuum of services delivered to HIV positive persons living in Westchester, Rockland, and Putnam counties, and to identify unmet needs for services. The interviews for this study present quantitative profiles of respondents' needs for health and human services, their encounters with health care and social service organizations, their satisfaction with services, and their current health status. The people who participated in the baseline survey are being re-interviewed at approximately annual intervals.

In 2001, the Planning and Evaluation Subcommittee of the New York HIV Health and Human Services Planning Council authorized the Westchester Department of Health (WDOH) and Medical and Health Research Association of New York City, Inc. (MHRA), to develop a longitudinal study of Tri-County residents living with HIV similar to the existing New York City longitudinal project. The Mailman School of Public Health at Columbia University was contracted by MHRA to conduct the survey and carry out analyses of survey data.

Sample Design

One of the major goals of this study is to assemble a cohort that is broadly representative of all Tri-County residents living with HIV. The simplest strategy for achieving this goal, drawing a random household sample, is not feasible because persons with HIV are relatively rare in the population, and many are, for good reason, reluctant to disclose their HIV seropositive status. Therefore, to approximate the ideal sample, several sampling strategies were developed.

Agency-based random recruitment

The first strategy involved sampling clients and patients drawn from rosters of agencies providing medical and social services to persons living with HIV. To achieve a representative sample of clients, a two-step sampling procedure was followed. The first step involved identifying all health and social service agencies in the Tri-County region providing HIV services to at least ten clients. Since there were only 31 agencies or sites of service identified during this procedure it was determined to sample clients from the entire universe of agencies rather than sampling from this list.

The second step involved recruiting a random sample of clients from each participating agency. Random selection of clients was intended to minimize the tendency of agencies to refer their most satisfied and/or easier-to-reach clients. Each agency that agreed to help recruit participants assembled a list containing anonymous identifiers for all persons living with HIV who had contact with the agency within a year of constructing the list, and also designated one of their employees to act as a liaison/coordinator between the Columbia team and the sampled individuals. In order to be eligible for the study, individuals had to be residents of Westchester, Rockland, or Putnam counties, at least 20 years of age, and HIV-positive for at least 6 months. The Columbia team randomly drew between 15 and 25 identifiers from each agency list. The identifiers were returned to the agency coordinators who made initial contact with the sampled clients to explain the purpose of the study and to determine if they were willing to participate. Only then did the agency coordinator send the names, addresses and telephone numbers of

consenting clients to the Columbia field staff to schedule and conduct the interviews.

Agency-based sequential enrollment

In addition the agency-based random recruitment we employed a sequential enrollment strategy, in which all clients present at a given site during a specific time period were invited to participate in the study. Such a strategy could only be used at sites with sufficient numbers of clients (nominally 10-20 clients, at a minimum), who would be present for such a recruitment. The Tri--County CHAIN Field Director would coordinate recruitment with an agency coordinator from the participating agency. The agency would maintain a roster of all eligible clients present during the recruitment period so that a later analysis could be conducted to determine if CHAIN recruited most (or all) eligible clients present, and if those recruited were reasonably representative of all eligible clients present.

Interview Schedule

All interviews are conducted in person by trained interviewers. The major topics covered during the interviews include (1) initial encounter with the health care delivery system, (2) need for services, (3) access, utilization and satisfaction with health and social services, (4) sociodemographic characteristics of respondents, (5) informal caregiving from friends, family and volunteers, and (6) quality of life with respect to health status, psychological and social functioning. The interview schedule was developed based upon a listing of questions under each of these broader topics that was circulated to the Planning and Evaluation Subcommittee, WDOH and MHRA. Whenever possible, interview questions were taken from earlier surveys administered to persons living with HIV and were designed to match questions asked of participants in the New York City CHAIN study. In particular, information on use of health and social services was obtained using questions developed for a federally funded study of AIDS service utilization. Health status was assessed using survey questions that have well established psychometric properties (such as the Medical Outcomes Survey scale, and indices measuring health locus of control, and self-efficacy) and which have been widely administered to HIV positive populations. The interview takes between two and three hours to complete, dependent upon issues relevant to each client's unique service needs. Most interviews were conducted in English, although fifteen were conducted in Spanish and six conducted in Creole. Sixteen of the three hundred and ninety-eight interviews were conducted on an abbreviated survey (a "short form") that captures most of the variables used in analyses. We have tried to note the appropriate denominator in the tables when the item being reported was not a part of the abbreviated form. These short forms were primarily used when respondents were physically or mentally unable to complete the entire survey.