



C.H.A.I.N. REPORT

Tri-County CHAIN

Report 2003-1

Service Gaps and Utilization in the Continuum of Care

David Abramson

Columbia University
Mailman School of Public Health
In collaboration with Medical and Health
Research Association of New York,
the NYC Department of Health and Mental
Hygiene, the Westchester Department of
Health, and the NY Health & Human Services
HIV Planning Council

Originally submitted May 30, 2003
Revised April 13, 2004
HRSA Grant # H89 HA 0015-12

ACKNOWLEDGMENTS

A Technical Review Team (TRT) provides oversight for the CHAIN Project in New York City and in the Tri-County area of Putnam, Rockland, and Westchester counties. In addition to Peter Messeri, PhD, Angela Aidala, PhD, and David Abramson, of Columbia University’s Mailman School of Public Health, TRT members include Mary Ann Chiasson, DrPH, MHRA (chair); Robert Cordero, NYCDOHMH Office of AIDS Policy; JoAnn Hilger, NYCDOHMH; Julie Lehane, PhD, Westchester County DOH; Jennifer Nelson, MHRA; and Ken Butler, PWA Advisory Group. Additionally, the Tri-County CHAIN project regularly consults with Tom Petro, Julie Lehane, Basil Reyes, and Renee Recchia of the Westchester County 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.

Tri-County CHAIN Project

Peter Messeri, PhD	Principal Investigator
David Abramson, MPH MPhil	Study Director
Barbara Bennet	Field Director
Tasha Stehling, MPH	Data Manager
Rachel Ferat	Office Manager & Research Assistant
Sandra Smartt & Dave Hunter	Data Editors
Narine Malcolm	Administrator

Interviewers: Sophia Luyando, Rose Rivera, Elizabeth Romero

This research was made possible by grant number H89 HA 0015-12 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

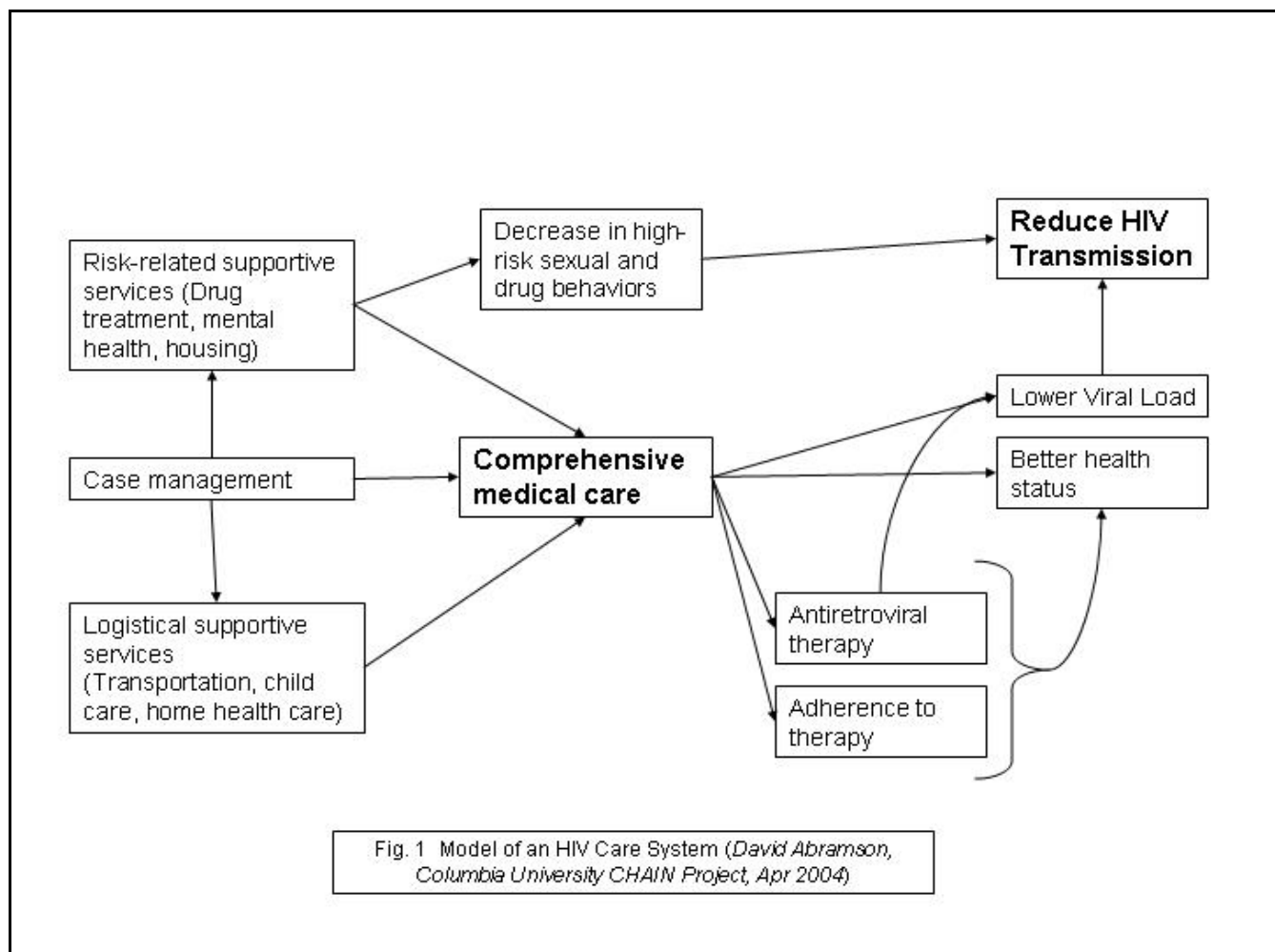
In earlier CHAIN reports and articles drawing upon data from the New York City cohort it was evident that ancillary services had a profound and statistically significant effect upon increasing individual's entry in to medical care and retention in medical care (see Messeri, Abramson et al, 2002; Abramson, Sanger et al 2001)¹. Case management, mental health services, drug treatment, and housing services were all positively associated with facilitating individuals' engagement with the medical care system. Conversely, unmet needs and service gaps among these key categories were negatively associated with entry and retention in medical care.

This report is an effort to provide a comprehensive look at service gaps and utilization within the continuum of care for respondents in the Tri-County CHAIN cohort. Figure 1, on the following page, illustrates an "ideal" model of an HIV care system, one that encompasses both health and social services. This model HIV care system provides three desired end-points: (1) Better physical health for HIV-positive individuals, (2) lower or undetectable viral loads, and (3) a reduction in HIV transmission or re-transmission from HIV-positive individuals to others. Central to the model is comprehensive medical care, which plays an essential role in facilitating appropriate therapies and disease management. Of nearly equal importance to comprehensive medical care is case management, which has been shown to assist individuals in engaging with medical care and maintaining continuity, either directly or through risk-reducing supportive services (such as drug treatment or mental health services) or through logistical supportive services (such as transportation or child care).

There are three main sections within this report – Service Gaps, Service Utilization, and Service Details. The service gaps section focuses on twelve sentinel measures across six major service categories (health, case management, housing, mental health, alcohol or drug treatment, and transportation), covering tables 2 through 5. The service utilization section (tables 6 through 10) examines service use patterns for individuals and subgroups in the Tri-County CHAIN cohort. The final section illustrates service details by subgroups and special populations (including Men of Color who have Sex with Men, mentally-ill chemical abusers, and individuals who have been unstably housed), in tables 11 through 35.

For most of these analyses, data were drawn from the baseline Tri-County CHAIN cohort survey. A number of previous CHAIN reports have described the sampling strategy, study protocols, and cohort characteristics (see the Data & Methods section at the end for a brief description). The 398 respondents were drawn in 2001 - 2002 as a representative sample of HIV-positive adults in the system of care in the Tri-County region. The first follow-up interviews were conducted in 2003. As illustrated in Table 1, of the 398 interviewed at baseline, 50 were ineligible due to death or having moved from the area. Of the remaining 348 eligible respondents, the project successfully interviewed 315 individuals, for a 91% retention rate.

¹ See D Abramson, N Sanger, P Messeri, MA Chiasson, "Assessing the Impact of the Ryan White CARE Act on Health Outcomes in New York City," report to the Health Resources & Services Administration, Nov 2001, and P Messeri, D Abramson, A Aidala, F Lee, G Lee, "The Impact of Ancillary HIV Services on Engagement in Medical Care in New York City," *AIDS Care*, 14(Suppl):S15-S30, August 2002.



There was a slightly disproportionate attrition among respondents who were unstably housed, in their 20s, and/or who lived in Rockland. Overall, however, the follow-up cohort of 315 individuals looks essentially like the baseline cohort of 398. In addition to using data from the follow-up interviews, selected comparisons were made between the Tri-County cohort and the second NYC CHAIN cohort, which was recruited in 2001 - 2003.

Several important caveats are in order for any reader. One should use great caution in interpreting any numbers or percentages in which the denominator (that is the size of the subgroup) is smaller than 50 people. In such instances, percentages will vary greatly, not be comparable or equivalent to groups greater than 50, and generally be very unstable. In the case of some of the special populations, in particular those respondents who immigrated within the past 3 years or those who were recently incarcerated, we had too few individuals to reliably report the findings. Finally, some of the actual denominators for specific cells within the tables are lower than the overall group number (that is, not everyone in the group may have answered that particular question). For the sake of readability, though, we have not cluttered the tables with all the denominators. We are happy to provide them if requested. Generally speaking, a difference of only a few individuals will not greatly affect most of the percentages. Also, for purposes of clarity and to facilitate a reader's use of the data, we have opted to present the data

as percentages rather than raw numbers. Since this is a representative cohort of HIV-positive adults in care in the Tri-County region, the absolute numbers are less important than the relative proportion of people using a specific service or identifying an unmet need. One rule of thumb that may be applied, however, is that CHAIN has sampled approximately one-quarter of all HIV-positive adults in the “public” system of care in Tri-County (that is, excluding those people who use private physicians and who do not access any social services). Therefore, it is not unreasonable to extrapolate out to the full population – at least at a minimum – by multiplying the absolute CHAIN numbers by a factor of four.

Finally, where possible we have indicated statistically significant differences with the use of asterisks. Our convention is that a single asterisk is significant at the .05 level, two asterisks at the .01 level, and three asterisks at the .001 level. In order to save space on those tabular pages we have omitted this legend.

Service Gaps

Table 2 illustrates how needs and service gaps have been defined for 12 sentinel measures. These measures were selected and refined after a series of public presentations in both New York City and Tri-County as well as the convening of a Tri-County provider advisory group and consultation with the Westchester Department of Health and with the CHAIN Technical Review Team. They are not intended to cover every service funded within an HIV system of care, but rather to represent guideposts for assessing the system. These measures were also limited by the data collected in the CHAIN survey, which although it includes over 900 variables is still dependent upon a respondent’s self-report. As such, a service gap may not measure directly whether the client received a particular service, but rather whether the client *perceived* receiving a specific service. This still provides powerful evidence. If a client believes that he or she has not received any case management (and cannot even identify anyone who has attempted to help them), one could argue that even if a case manager has provided services for a client it has likely had little impact.

CHAIN data may be used to measure “subjectively expressed” and “objectively assessed” needs. To illustrate, if a client reports that she needs or has sought out housing services, that is subjectively expressed by the client herself. If, on the other hand, a client reports that she has been unstably housed in the past 6 months – perhaps doubled-up on a friend’s couch – that would be regarded as an objectively assessed need. If either is present, the client is regarded as having a need for housing services. A service gap would exist if the client reported that she had not received any housing services in the prior six months or she isn’t living in specialized AIDS housing (which could be construed as a potential “solution” to her housing problems). For some health services, such as comprehensive medical care and patient/provider communication, it has been assumed that all HIV-positive adults have a presumptive need for that service.

Key Findings

- In comparing the baseline Tri-County cohort (n=398) with the baseline NYC II cohort (n=622) as illustrated in Table 3, many of the needs are remarkably similar. Among the

differences are a greater need in Tri-County for financial housing services and transportation services.

- When looking at the service gaps between the Tri-County and NYC cohorts, there are several notable differences. There are significantly larger service gaps in Tri-County for patient/provider communication, both financial and permanent housing services, and for supportive mental health services (such as support groups, peer educators and supportive clergy). Even where the gaps are similar between Tri-County and NYC, though, several areas register as a high proportion of service gaps: among those with a need for comprehensive case management (the “social work model”) 45% report a service gap. Among those with a need for professional mental health services, 55% report a service gap. And perhaps most alarmingly, among those with a need for drug or alcohol treatment services, 76% report a service gap.
- Table 4 illustrates differences in needs and service gaps between the baseline interviews (wave 1) and the first follow-up interviews (wave 2). Although most of the needs have remained relatively constant, several have increased over time – the need for treatment adherence services, the need for comprehensive case management and counseling case management, and the need for transportation services. In terms of service gaps, there are significant increases between the baseline and follow-up interviews for permanent housing services, professional mental health services, and transportation services. There was a decrease in service gaps related to antiretroviral therapy (meaning more people with t-cells below 200 were on combination therapy in wave 2 than in wave 1).
- Table 5 illustrates which subgroups are significantly more likely to report specific needs or service gaps in Tri-County. Women express a greater need than men for comprehensive case management, financial and permanent housing services, professional mental health services, and transportation services. Women also report a greater service gap than men regarding patient/provider communications. Problem drug users – defined as individuals who have ever used cocaine, crack, or heroin three or more times a week for a month or more, or who have a significant alcohol problem, or who have ever injected drugs – are more likely to report a need for comprehensive case management and for counseling case management. Respondents living in urban Westchester (south of Route 287) and Rockland were more likely to report a service gap for professional mental health than were respondents living in suburban Westchester and Putnam counties.

Service Utilization

As illustrated in the notes to Table 6, service utilization data refer to client-reported services in the 6-month period preceding the interview, and are reported for the baseline interview (n=398). Several service categories, such as hospice or outreach activities, were excluded because CHAIN data cannot adequately capture them. The utilization data are not contingent upon need. In other words, an individual may report mental health services even if there are no subjective or objective expressions of need for mental health services. Subgroup comparisons are provided by gender, race/ethnicity, HIV risk, geography, special populations

(Men of color who have sex with men, mentally-ill chemical abusers, and individuals who have been unstably housed), and by health planning regions. As noted above, in some instances the absolute number of individuals in a group may be too small to reliably note proportional differences (particularly vulnerable are groups with fewer than 50 individuals).

Key Findings

- Overall, as illustrated in Table 6, the three highest areas of service utilization are primary medical care (95%), case management (74%), and dental care (71%). Mental health services (38%) housing financial assistance (30%), and treatment adherence services (51%) are used moderately. Housing, substance use, food, and transportation services are used by relatively few people in the cohort (12-19% of the cohort), and legal and home health care are used by very few respondents (4-6% of the cohort) [see Table 1b].
- Several subgroup differences did emerge in these analyses [see Tables 7 through 10]. White respondents are more likely than black respondents to report mental health services, as are individuals who live in suburban Westchester and Putnam counties. Women and individuals living in Rockland county are more likely to report use of financial housing services, and men of color who have sex with men and unstably housed are less likely to report use of these services. Predictably, mentally-ill chemical abusers are more likely to report drug treatment services, as are individuals who reported unstable housing.

Service Details

Tables 11 through 35 represent more of an unfiltered look at client responses to the CHAIN survey, as well as subgroup differences. Rather than create composite variables for measures of need or service gaps, we present the data representing the underlying responses to questions regarding insurance coverage, medical care, supportive services, substance abuse and mental health services, and housing and financial needs. The items are not mutually exclusive. Respondents may have provided multiple responses to a single question. For example, in Table 11, in response to the question “What kind of insurance do you currently have?” respondents may answer that they have Medicare and Medicaid.

Key Findings

- In looking at tables 11 through 15, men are more likely to report Medicare coverage than women, as are whites more likely to report Medicare coverage than black or Latino respondents. Problem drug users are more likely to report Medicaid coverage, and among these problem drug users women are more likely than men to report Medicaid coverage. MSM are more likely to report ADAP coverage, and women problem drug users are the least likely to report ADAP coverage. Men of color who have sex with men are significantly more likely than others in the cohort to have lost health insurance coverage in the past 6 months.
- Tables 16 through 20 cover issues related to medical care. There are few subgroup

differences. White respondents are more likely than black or Latino respondents to report use of alternative health services, and MSM are more likely to report having seen a private medical provider in the past 6 months.

- Tables 21 through 25 illustrate subgroup differences related to supportive services. Women are more likely than men to have reported needing help with food or groceries in the past 6 months, having a case manager who developed a care plan or referred them to medical services, or needing help with transportation, child care or home care in the prior 6 months. Latinos were far more likely than white respondents to report that their case managers counseled them about safer sex practices. Mentally-ill chemical abusers reported a greater number of case managers (2.0) than the rest of the cohort (1.7).
- Tables 26 through 30 represent data related to substance abuse and mental health issues. Women were more likely than men to report a need for help with emotional or psychological issues in the past 6 months, as were white and Latino respondents, and particularly mentally-ill chemical abusers. Black and Latino respondents were far more likely than white respondents to report having ever received drug treatment.
- Tables 31 through 35 illustrate findings related to housing and financial needs. White respondents are more likely than black or Latino respondents to own their home and less likely to report a need for housing help. They are more likely to report having received assistance with financial matters in the prior 6 month period. Finally, as would be expected, mentally-ill chemical abusers and respondents who had been unstably housed were more likely to report a need for housing help and a need for financial assistance in the prior six month period.

Table 1. Analysis of Tri-County CHAIN Cohort Attrition: Comparing Baseline (Wave 1) to Follow-up (Wave 2)

Characteristic	Interviewed at Wave 1	Interviewed at Wave 2	Ineligible at Wave 2	Not Interviewed at Wave 2
	398	315	50	33
Gender *				
<i>Men</i>	51%	48%	68%	52%
<i>Women</i>	49%	52%	32%	48%
Age**				
<i>20-34</i>	11%	10%	8%	27%
<i>35-49</i>	61%	64%	56%	46%
<i>50+</i>	28%	26%	36%	27%
Race/Ethnicity				
<i>White</i>	21%	21%	26%	18%
<i>Black</i>	50%	52%	52%	52%
<i>Latino</i>	28%	26%	26%	30%
<i>Other</i>	2%	1%	2%	0%
Housing Status **				
<i>Stable</i>	82%	85%	68%	76%
<i>Double</i>	9%	8 %	12%	18%
<i>Unstable</i>	8%	7 %	20%	6 %
Location **				
<i>Urban Westchester</i>	54%	56%	46%	39%
<i>Suburban West/Putnam</i>	28%	29%	28%	21%
<i>Rockland</i>	18%	15%	26%	39%

* p < .05

** p < .01

*** p < .001

Note: Respondents were classified as ineligible in between the baseline (Wave 1) and follow-up (Wave 2) interviews for the following reasons: death (22), moved from area (26), mentally unable to participate in study (1), discovered to be HIV-negative (1).

Table 2. Measuring Needs & Service Gaps – Definitions

Service	NEED	SERVICE GAP
HEALTH		
Comprehensive medical care	Positive HIV serostatus	Primary HIV medical provider does not provide ALL of the following: (1) Routine check-ups, well visits, vaccinations, (2) Source of health advice, (3) 24-hour access for medical emergencies
Patient/Provider communication	Positive HIV serostatus	Patient doesn't know t-cell or viral load, OR says current doctor "could do a better job explaining my treatment options to me"
Treatment adherence	On antiretroviral medications	Among non-adherent, not receiving treatment adherence services
Antiretroviral therapy	T-cell less than 200	Not on antiretroviral combination therapy
CASE MANAGEMENT		
CM: Comprehensive care model	(1) Current drug user OR (2) very low mental health score OR (3) recent episode of unstable housing OR (4) experienced a barrier to medical or social service because didn't know where to go, couldn't get child care, couldn't get transportation, or couldn't afford care or (5) says there's not enough money in the household for rent, utilities, food, or clothing	Among those with a need, no CM developed a care plan, assisted in getting or referring client to social services, or helped fill out forms for benefits or entitlements in past 6 months
CM: Counseling model	(1) Scored very low on mental health score OR (2) current drug user OR (3) practiced unsafe sex in past 6 months	Among those with a need, no CM counseled client regarding personal life, drug or alcohol problems, practicing safer sex, or periodically checked up on client in past 6 months
HOUSING		
Financial Housing Services	(1) Fairly often or very often not enough \$\$\$ for rent, OR (2) reported that s/he needed help with eviction, paying rent, or maintaining rental subsidy	No housing service received, OR client not living in specialized AIDS housing
Permanent Housing Services	(1) At least one episode of unstable housing or doubled-up in past 6 months, OR (2) reported that s/he needed help related to homelessness, critical need to move, physical access issues, poor housing quality, or dangerous neighborhood	No housing service received, OR client not living in specialized AIDS housing

Service	NEED	SERVICE GAP
MENTAL HEALTH		
Professional Mental Health	Scored very low on a mental health score (Mental component summary (MCS) ≤ 37.0)	Respondent did not report receipt of professional MH service (psychiatrist, psychologist, therapist, therapeutic social worker) in prior 6 months
Supportive Mental Health	Scored above 37.0 on mental health score AND (1) reported a need for help with emotional or psychological problems OR (2) felt counseling regarding sexuality and sexual issues was considerably or extremely important OR (3) strongly disagreed that "most of the time I am in firm control of my feelings and behavior"	Respondent did not report receipt of supportive MH service (support groups, clergy, case managers, peer workers) in prior 6 months
ALCOHOL OR DRUGS (AOD)		
AOD	(1) Current drug or heavy alcohol user OR (2) client said that treatment or further treatment is "considerably" or "extremely" important	No reported therapeutic or self-help AOD treatment in prior 6 months
TRANSPORTATION		
Transportation Services	(1) Delayed or didn't get med or soc svce because couldn't get transportation, OR (2) reported that s/he needed help or assistance with transportation in prior 6 months	No reported transportation service in prior 6 months

Table 3. Measuring Needs & Service Gaps – Comparing Tri-County & NYC

Service	Tri-County				NYC			
	NEED		SERVICE GAP		NEED		SERVICE GAP	
	Number with need	Proportion of Full Cohort (n=398) with Need	Among those with Need, the Number with a Service Gap	Proportion of those with Need Experiencing Service Gap	Number with Need	Proportion of Full Cohort (n=622) with Need	Among those with Need, the Number with a Service Gap	Proportion of those with Need Experiencing Service Gap
HEALTH								
Comprehensive medical care	398	100%	115	29%	622	100%	148	24%
Patient/ Provider communication	398	100%	186	47%	622	100%	235	38%
Treatment adherence	275	69%	38	14%	440	71%	82	19%
Antiretroviral therapy	65	16%	15	23%	127	20%	35	28%
CASE MANAGEMENT								
CM: Social work model	307	77%	137	45%	466	75%	186	40%
CM: Counseling model	180	45%	72	40%	348	56%	134	39%
HOUSING								
Financial Housing Services	135	34%	74	55%	156	25%	50	32%
Permanent Housing Services	70	18%	27	39%	126	20%	37	29%
MENTAL HEALTH								
Professional Mental Health	131	33%	74	55%	233	37%	147	63%
Supportive Mental Health	70	18%	45	64%	85	14%	29	34%
ALCOHOL OR DRUGS								
AOD	252	63%	190	76%	440	71%	309	70%
TRANSPORTATION								
Transportation Services	128	32%	85	67%	132	21%	101	77%

Table 4. Measuring Needs & Service Gaps – Comparing Waves 1 & 2

Service	Tri-County Wave 1 (2001-2002)				Tri-County Wave 2 (2003)			
	NEED		SERVICE GAP		NEED		SERVICE GAP	
	Number with need	Proportion of Full Cohort (n=398) with Need	Among those with Need, the Number with a Service Gap	Proportion of those with Need Experiencing Service Gap	Number with Need	Proportion of Full Cohort (n=315) with Need	Among those with Need, the Number with a Service Gap	Proportion of those with Need Experiencing Service Gap
HEALTH								
Comprehensive medical care	398	100%	115	29%	315	100%	89	28%
Patient/ Provider communication	398	100%	186	47%	315	100%	167	53%
Treatment adherence	275	69%	38	14%	238	76%	34	14%
Antiretroviral therapy	65	16%	15	23%	52	17%	8	15%
CASE MANAGEMENT								
CM: Social work model	307	77%	137	45%	269	85%	120	45%
CM: Counseling model	180	45%	72	40%	163	52%	76	47%
HOUSING								
Financial Housing Services	135	34%	74	55%	105	33%	56	53%
Permanent Housing Services	70	18%	27	39%	71	23%	41	58%
MENTAL HEALTH								
Professional Mental Health	131	33%	74	55%	114	36%	77	68%
Supportive Mental Health	70	18%	45	64%	60	19%	36	60%
ALCOHOL OR DRUGS								
AOD	252	63%	190	76%	183	58%	132	72%
TRANSPORTATION								
Transportation Services	128	32%	85	67%	139	44%	115	83%

Table 5. Measuring Needs & Service Gaps – Subgroup Differences at Wave 1*

Service	NEED	SERVICE GAP
	Groups significantly more likely to experience a need	Groups significantly more likely to experience a service gap
HEALTH		
Comprehensive medical care		– Whites & Latinos
Patient/Provider communication		– Women
Treatment adherence	– Men – Blacks & Latinos	
Antiretroviral therapy	– Men – Blacks & Latinos	
CASE MANAGEMENT		
CM: Social work model	– Women – Problem drug users – MSM who were problem drug users	– Men
CM: Counseling model	– Women – Latinos – Problem drug users – MSM who were problem drug users	
HOUSING		
Financial Housing Services	– Women	
Permanent Housing Services	– Women	
MENTAL HEALTH		
Professional Mental Health	– Women – Latinos	– Urban Westchester and Rockland
Supportive Mental Health	– Men	
ALCOHOL OR DRUGS		
AOD	– Latinos and Blacks	– MSM – Heterosexual HIV risk behavior – Urban Westchester and Rockland
TRANSPORTATION		
Transportation Services	– Women – Heterosexual HIV risk	

* Note: These data represent statistical tests for subgroup differences by gender, race/ethnicity, HIV risk behavior, and geographic area. “Problem drug users” are defined as individuals who have used cocaine, crack, or heroin three or more times a week for a month or more, or who have ever injected drugs, or who meet the CAGE criteria for heavy drinking.

Table 6. Service Utilization (Tri-County CHAIN data, 2001-2002)

Service	# Who Received Service	% Baseline Cohort (n=398) who Received Service
<i>Ambulatory Medical Care</i>	379	95%
<i>Case Management</i>	292	74%
<i>Dental Care</i>	284	71%
<i>Child Care</i>	50	13%
<i>Drug Treatment – MMTP</i>	21	5%
<i>Drug Treatment – Out-patient</i>	19	5%
<i>Drug Treatment – Self-help</i>	48	12%
<i>Emergency Financial Assistance</i>	23	6%
<i>Food Bank/Home delivered</i>	69	17%
<i>Home Health Care</i>	17	4%
<i>Housing Services (any)</i>	76	19%
<i>Housing Services – financial assistance</i>	118	30%
<i>Legal Services</i>	25	6%
<i>Mental Health Services</i>	152	38%
<i>Substance Use Services</i>	70	18%
<i>Transportation Services</i>	47	12%
<i>Treatment Adherence Servcs</i>	156	51%

Notes

Amb med care = any reported HIV primary medical care.

Case management = any reported case management or case worker assistance.

Dental care = any reported dental service.

Child care = any babysitting, day care, or child care services

Self-help drug treatment = includes Alcoholics Anonymous, Narcotics Anonymous, and other self-help groups.

Emergency financial assistance = refers to HEAP and assistance with utilities and other cash outlays.

Home health care = refers to any reported assistance with activities of daily living.

Housing services (any) = refers to any placement or financial assistance services

Housing services - financial assistance = refers to any rental subsidy or emergency financial rental assistance.

Mental health services = refer to any professional (psychiatrist or therapist) or supportive (support group, peer)

Substance use services = refer to any therapeutic or self-help drug treatment.

Treatment adherence services - refer to any assistance reported by client is taking their HIV medications.

**Table 7. Service Utilization by RACE/ETHNICITY & GENDER,
(Tri-County CHAIN data, 2001-2002)**

Service	RACE/ETHNICITY			GENDER	
	White, non- Hispanic	Black, non- Hispanic	Hispanic	Male	Female
<i>TOTAL (n)</i>	82	197	110	204	194
<i>Ambulatory Medical Care</i>	95%	95%	96%	96%	95%
<i>Case Management</i>	73%	74%	74%	71%	76%
<i>Child Care</i>	10	16%	9%	11%	14%
<i>Dental Care</i>	74%	70%	71%	72%	71%
<i>Drug Treatment – MMTP</i>	4%	5%	7%	4%	6%
<i>Drug Treatment – Out-patient</i>	2%	6%	5%	6%	3%
<i>Drug Treatment – Self-help</i>	10%	13%	12%	15%	9%
<i>Emergency Financial Assistance</i>	10%	4%	7%	6%	6%
<i>Food Bank/Home delivered</i>	23%	17%	14%	15%	20%
<i>Home Health Care</i>	7%	5%	1%	3%	5%
<i>Housing Services (any)</i>	17%	19%	22%	18%	21%
<i>Housing Services – financial assistance</i>	30%	28%	31%	21%***	39%
<i>Legal Services</i>	10%	6%	6%	6%	6%
<i>Mental Health Services</i>	52%**	31%	40%	39%	37%
<i>Substance Use Services</i>	13%	19%	19%	19%	16%
<i>Transportation Services</i>	12%	13%	12%	10%	14%
<i>Treatment Adherence Servcs</i>	45%	55%	51%	51%	52%

**Table 8. Service Utilization by RISK & GEOGRAPHY,
(Tri-County CHAIN data, 2001-2002)**

Service	RISK				GEOGRAPHY		
	MSM	PDU	MSM + PDU	Hetero	Urban Westchester	Suburban Westchester/ Putnam	Rockland
<i>TOTAL (n)</i>	62	164	19	153	213	112	73
<i>Ambulatory Medical Care</i>	94%	97%	100%	93%	95%	97%	92%
<i>Case Management</i>	76%	72%	84%	74%	72%	78%	72%
<i>Child Care</i>	3%	15%	5%	14%	15%	9%	11%
<i>Dental Care</i>	74%	68%	84%	72%	71%	73%	68%
<i>Drug Treatment – MMTP</i>	0%	13%	0%	0%	6%	6%	3%
<i>Drug Treatment – Out-patient</i>	3%	6%	11%	3%	5%	6%	1%
<i>Drug Treatment – Self-help</i>	5%***	21%	21%	5%	10%	16%	11%
<i>Emergency Financial Assistance</i>	6%	5%	11%	6%	5%	4%	11%
<i>Food Bank/Home delivered</i>	11%	16%	26%	20%	15%	20%	19%
<i>Home Health Care</i>	3%	5%	0%	5%	5%	3%	4%
<i>Housing Services (any)</i>	18%	22%	16%	17%	22%	15%	16%
<i>Housing services – financial</i>	21%	31%	21%	33%	30%*	22%	41%
<i>Legal Services</i>	6%	4%	16%	8%	3%**	7%	14%
<i>Mental Health Services</i>	35%	42%	53%	33%	35%***	53%	25%
<i>Substance Use Services</i>	5%	33%	26%	5%	17%	23%	13%
<i>Transportation Services</i>	10%	12%	16%	13%	10%	17%	11%
<i>Treatment Adherence Servs</i>	55%	54%	44%	47%	55%	47%	46%

Table 9. Service Utilization by SPECIAL POPULATIONS

<i>Service</i>	MCSM	MICA	Unstably housed
<i>TOTAL (n)</i>	50	28	70
<i>Ambulatory Medical Care</i>	96%	100%	91%
<i>Case Management</i>	82%	79%	78%
<i>Child Care</i>	4%*	11%	14%
<i>Dental Care</i>	80%	61%	64%
<i>Drug Treatment – MMTP</i>	0%	18%**	10%*
<i>Drug Treatment – Out-patient</i>	8%	11%	10%*
<i>Drug Treatment – Self-help</i>	14%	29%**	21%**
<i>Emergency Financial Assistance</i>	4%	11%	1%
<i>Food Bank/Home delivered</i>	12%	21%	10%
<i>Home Health Care</i>	2%	7%	1%
<i>Housing Services (any)</i>	16%	32%	20%
<i>Housing Services – financial</i>	18%*	25%	17%**
<i>Legal Services</i>	6%	7%	9%
<i>Mental Health Services</i>	40%	57%	39%
<i>Substance Use Services</i>	16%	43%	30%
<i>Transportation Services</i>	12%	18%	10%
<i>Treatment Adherence Servcs</i>	53%	58%	47%

Table 10. Service Utilization by HEALTH PLANNING REGION

	NEast	WCent	NWest	ECent	SEast	SWest	Rock	Put
<i>TOTAL (n)</i>	8	24	49	8	86	132	73	18
<i>Ambulatory Medical Care</i>	100%	100%	98%	88%	94%	96%	92%	94%
<i>Case Management</i>	100%	67%	80%	88%	69%	73%	72%	89%
<i>Child Care</i>	0%	8%	10%	13%	10%	18%	11%	6%
<i>Dental Care</i>	88%	79%	67%	88%	67%	72%	68%	83%
<i>Drug Treatment – MMTP</i>	13%	13%	2%	13%	7%	5%	3%	6%
<i>Drug Treatment – Out-patient</i>	0%	8%	6%	0%	5%	5%	1%	11%
<i>Drug Treatment – Self-help</i>	25%	13%	14%	13%	9%	11%	11%	22%
<i>Emergency Financial Assistance</i>	13%	4%	2%	13%	5%	5%	11%	6%
<i>Food Bank/Home delivered</i>	13%	13%	22%	0%	14%	16%	19%	39%
<i>Home Health Care</i>	0%	0%	2%	13%	6%	5%	4%	6%
<i>Housing Services (any)</i>	0%	17%	10%	25%	13%	29%	16%	22%
<i>Housing Services – financial</i>	13%	17%	27%	0%	31%	29%	41%	28%
<i>Legal Services</i>	0%	4%	8%	13%	2%	5%	14%	6%
<i>Mental Health Services</i>	63%	38%	53%	25%	27%	42%	25%	78%
<i>Substance Use Services</i>	50%	25%	16%	25%	17%	16%	13%	28%
<i>Transportation Services</i>	25%	13%	17%	13%	10%	9%	11%	28%
<i>Treatment Adherence Servcs</i>	29%	60%	35%	57%	55%	55%	46%	62%

Table 11. Insurance coverage by GENDER and RACE/ETHNICITY

Service	TOTAL	GENDER		RACE / ETHNICITY		
		Male	Female	White	Black	Latino
N	398	204	194	82	197	110
What kind of insurance do you currently have?						
<i>Private insurance</i>	7%	6%	8%	16%***	4%	5%
<i>Private HMO</i>	3%	2%	3%	4%	1%	5%
<i>Medicaid</i>	67%	64%	70%	55%	74%	64%
<i>Medicare</i>	23%	28%*	17%	40%***	21%	14%
<i>CAMPUS/CHAMPVA</i>	0%	0%	0%	0%	0%	0%
<i>Other private</i>	2%	3%	1%	4%	3%	1%
<i>Other public</i>	2%	2%	2%	1%	2%	2%
<i>ADAP/ADAP+</i>	29%	34%*	24%*	42%	23%	21%
<i>None</i>	1%	1%	1%	0%	2%	2%
% lost health insurance coverage in past 6 months	6%	4%	7%	4%	6%	7%
Type of coverage lost						
<i>Private insurance</i>	13%	13%	14%	0%	20%	0%
<i>Private HMO</i>	4%	13%	0%	0%	0%	14%
<i>Medicaid</i>	65%	50%	79%	67%	60%	86%
<i>Medicare</i>	0%	0%	0%	0%	0%	0%
<i>ADAP/ADAP+</i>	13%	25%	7%	33%	20%	0%
% covered by Medicaid last 6 mo	67%	65%	70%	57%*	74%	64%
% covered by Medicare last 6 mo	24%	30%*	18%*	40%***	21%	16%
% in Medicaid/Medicare HMO last 6 mo	8%	8%	8%	9%	6%	11%
% declining medical care because not covered by insurance	10%	9%	10%	15%	7%	11%
Insurance benefits adequate to cover needs...						
<i>Strongly agree</i>	54%	56%	53%	48%	56%	56%
<i>Agree</i>	35%	34%	35%	35%	37%	32%
<i>Disagree</i>	8%	8%	8%	14%	4%	10%
<i>Strongly disagree</i>	3%	2%	3%	4%	3%	2%
% Stopped protease b/c not covered by insurance	0%	0%	0%	0%	0%	0%

Table 13. Insurance coverage by RISK

	MSM	PDU	MSM + PDU	HETERO
N	62	164	19	153
What kind of insurance do you currently have?				
<i>Private insurance</i>	15%	4%	0%	8%
<i>Private HMO</i>	2%	2%	5%	3%
<i>Medicaid</i>	55%***	80%	63%	58%
<i>Medicare</i>	23%**	34%	9%	25%
<i>CAMPUS/CHAMPVA</i>	0%	0%	0%	0%
<i>Other private</i>	5%	1%	0%	3%
<i>Other public</i>	3%	1%	0%	1%
<i>ADAP/ADAP+</i>	44%***	15%	47%	36%
<i>None</i>	0%**	1%	0%	2%
% lost health insurance coverage in past 6 months	8%	5%	5%	6%
Type of coverage lost				
<i>Private insurance</i>	20%	0%	0%	22%
<i>Private HMO</i>	0%	0%	0%	11%
<i>Medicaid</i>	60%	86%	100%	56%
<i>Medicare</i>	0%	0%	0%	0%
<i>ADAP/ADAP+</i>	20%	14%	0%	11%
% covered by Medicaid last 6 mo	55%***	81%	63%	58%
% covered by Medicare last 6 mo	39%**	21%	47%	18%
% in Medicaid/Medicare HMO last 6 mo	13%	7%	6%	8%
% declining medical care because not covered by insurance	15%	5%	6%	12%
Insurance benefits adequate to cover needs...				
<i>Strongly agree</i>	52%	60%	67%	48%
<i>Agree</i>	30%	34%	28%	38%
<i>Disagree</i>	15%	4%	0%	11%
<i>Strongly disagree</i>	3%	3%	6%	3%
% Stopped protease because not covered by insurance	0%	0%	0%	0%

Table 14. Insurance coverage by RISK & RACE/ETHNICITY

	MSM	PDU		MSM + PDU	HETERO	
		Male	Female		Male	Female
N	62	85	79	19	38	115
What kind of insurance do you currently have?						
<i>Private insurance</i>	15%	1%	6%	0%	5%	9%
<i>Private HMO</i>	2%	2%	1%	5%	3%	3%
<i>Medicaid</i>	55%	78%	82%**	63%	50%	61%
<i>Medicare</i>	37%*	24%	16%	47%	13%	17%
<i>CAMPUS/CHAMPVA</i>	0%	0%	0%	0%	0%	0%
<i>Other private</i>	5%	2%	0%	0%	5%	2%
<i>Other public</i>	3%	2%	1%	0%	0%	2%
<i>ADAP/ADAP+</i>	44%**	21%	9%***	47%	39%	35%
<i>None</i>	0%*	1%	1%	0%	5%	1%
% lost insurance in past 6 months	8%	2%	8%	5%	3%	7%
Type of coverage lost						
<i>Private insurance</i>	20%	0%	0%	0%	0%	25%
<i>Private HMO</i>	0%	0%	0%	0%	100%	0%
<i>Medicaid</i>	60%	0%	100%	100%	0%	63%
<i>Medicare</i>	0%	0%	0%	0%	0%	0%
<i>ADAP/ADAP+</i>	20%	100%	0%	0%	0%	1%
% covered by Medicaid last 6 mo	55%*	79%	84%**	63%	50%	61%
% covered by Medicare last 6 mo	39%*	26%	16%	47%	16%	18%
% in Medicaid/Medicare HMO last 6 mo	13%	6%	8%	6%	11%	8%
% decline med care b/c not covrd by insur	15%	5%	6%	6%	12%	13%
Insurance benefits adequate to cover needs...						
<i>Strongly agree</i>	52%	59%	60%	67%	50%	48%
<i>Agree</i>	30%	36%	32%	28%	38%	38%
<i>Disagree</i>	15%	4%	4%	0%	12%	11%
<i>Strongly disagree</i>	3%	1%	4%	6%	0%	4%
% Stopped protease b/c not covrd by insurance	0%	0%	0%	0%	0%	0%

Table 15. Insurance coverage by SPECIAL POPULATIONS

	MCSM	MICA	Unstably housed
N	50	28	70
What kind of insurance do you currently have?			
<i>Private insurance</i>	2%	14%	0%*
<i>Private HMO</i>	4%	0%	0%
<i>Medicaid</i>	66%	71%	71%
<i>Medicare</i>	40%	11%	14%
<i>CAMPUS/CHAMPVA</i>	0%	0%	0%
<i>Other private</i>	4%	0%	0%
<i>Other public</i>	4%	0%	3%
<i>ADAP/ADAP+</i>	44%*	25%	26%
<i>None</i>	0%	0%	4%*
% lost health insurance coverage in past 6 months	12%*	11%	6%
Type of coverage lost			
<i>Private insurance</i>	17%	0%	0%
<i>Private HMO</i>	0%	0%	0%
<i>Medicaid</i>	67%	100%	100%
<i>Medicare</i>	0%	0%	0%
<i>ADAP/ADAP+</i>	17%	0%	0%
<i>Other private</i>	0%	0%	0%
<i>Other public</i>	0%	0%	0%
% covered by Medicaid last 6 mo	66%	71%	71%
% covered by Medicare last 6 mo	42%	14%	14%
% in Medicaid/Medicare HMO last 6 mo	87%	9%	15%
% declining medical care because not covered by insurance	13%	14%	9%
Insurance benefits adequate to cover needs...			
<i>Strongly agree</i>	60%	54%	56%
<i>Agree</i>	32%	36%	31%
<i>Disagree</i>	6%	7%	9%
<i>Strongly disagree</i>	2%	4%	3%
% Stopped protease because not covered by insurance	0%	0%	0%

Table 16. Medical Care by GENDER and RACE/ETHNICITY

Service	TOTAL	GENDER		RACE / ETHNICITY		
		Male	Female	White	Black	Latino
N	398	204	194	82	197	110
Ever seen doctor/med provider for HIV	99%	100%	100%	100%	100%	99%
Have a current medical provider for HIV	11%	96%	95%	95%	95%	96%
Gone to hospital clinic or OPD in past 6 months	63%	65%	62%	54%	70%	62%
Gone to other medical clinic (ie community) past 6 mo	24%	22%	27%	28%	20%	28%
Used mobile medical van past 6 months	4%	2%	6%	4%	4%	6%
Gone to private medical provider past 6 months	20%	23%	17%	48%	10%	14%
Received home health care past 6 months	9%	7%	10%	12%	9%	6%
Received treatment adherence service past 6 months	39%	54%	53%	46%	57%	56%
Seen dentist in past 6 months	54%	52%	56%	54%	52%	56%
Seen alternative health provider / healer in past 6 months	8%	6%	9%	13%*	5%	8%
Stayed in nursing home, hospice, residential care for at least one night in past 6 months	4%	5%	3%	4%	6%	2%
At least one in-patient stay in past 6 months	22%	20%	24%	18%	22%	25%
At least one emergency room visit in past 6 months	35%	32%	38%	28%	40%	31%

Table 17. Medical Care by HEALTH PLANNING REGION

	SEast	SWest	WCent	NWest	ECent	NEast	Put	Rock
N	86	132	24	49	8	8	18	73
Ever seen doctor/med provider for HIV	99%	100%	100%	100%	100%	100%	100%	100%
Have a current medical provider for HIV	94%	96%	100%	98%	88%	100%	94%	92%
Gone to hospital clinic or OPD in past 6 months	65%	71%	63%	53%	63%	63%	50%	53%
Gone to other medical clinic (ie community) past 6 mo	16%***	14%	25%	47%	25%	38%	17%	39%
Used mobile medical van past 6 months	5%	4%	4%	2%	25%	0%	6%	3%
Gone to private medical provider past 6 months	8%	15%	38%	20%	0%	25%	56%	29%
Received home health care past 6 months	8%	11%	13%	2%	0%	0%	11%	10%
Received treatment adherence service past 6 months	55%	58%	60%	42%	67%	29%	62%	49%
Seen dentist in past 6 months	55%	56%	58%	53%	38%	63%	61%	47%
Seen alternative health provider / healer in past 6 months	5%**	15%	13%	0%	0%	0%	17%	1%
Stayed in nursing home, hospice, residential care for at least one night in past 6 months	0%*	84%	8%	0%	13%	13%	0%	1%
At least one in-patient stay in past 6 months	20%	24%	25%	18%	13%	38%	11%	26%
At least one emergency room visit in past 6 months	34%	43%	33%	22%	25%	25%	44%	31%

Table 18. Medical Care by RISK

	MSM	PDU	MSM + PDU	HETERO
N	62	162	19	150
Ever seen doctor/med provider for HIV	100%	100%	100%	99%
Have a current medical provider for HIV	94%*	97%	100%	93%
Gone to hospital clinic or OPD in past 6 months	60%	67%	58%	62%
Gone to other medical clinic (ie community) past 6 mo	29%	24%	32%	23%
Used mobile medical van past 6 months	2%	4%	0%	5%
Gone to private medical provider past 6 months	34%**	16%	32%	17%
Received home health care past 6 months	13%	6%	0%	10%
Received treatment adherence service past 6 months	57%	58%	50%	49%
Seen dentist in past 6 months	58%	48%	63%	57%
Seen alternative health provider / healer in past 6 months	8%	8%	5%	8%
Stayed in nursing home, hospice, residential care for at least one night in past 6 months	2%	5%	11%	3%
At least one in-patient stay in past 6 months	23%	26%	16%	19%
At least one emergency room visit in past 6 months	31%	39%	42%	31%

Table 19. Medical Care by RISK & RACE/ETHNICITY

	MSM	PDU		MSM + PDU	HETERO	
		Male	Fem		Male	Fem
N	62	84	78	19	36	114
Ever seen doctor/med provider for HIV	100%	100%	100%	100%	97%	100%
Have a current medical provider for HIV						
Gone to hospital clinic or OPD in past 6 months	60%	71%	63%	58%	62%	61%
Gone to other medical clinic (ie community) past 6 mo	29%	14%	34%	32%	24%	22%
Used mobile medical van past 6 months	2%	2%	6%	0%	2%	6%
Gone to private medical provider past 6 months	34%	16%	15%	32%	16%	18%
Received home health care past 6 months	13%	4%	9%	0%	8%	12%
Received treatment adherence service past 6 months	57%	54%	62%	50%	53%	18%
Seen dentist in past 6 months	58%	47%	49%	63%	49%	60%
Seen alternative health provider / healer in past 6 months	8%	7%	9%	5%	16%	3%
Stayed in nursing home, hospice, residential care for at least one night in past 6 months	2%	8%	3%	11%	0%	18%
At least one in-patient stay in past 6 months	23%	24%	14%	16%	11%	29%
At least one emergency room visit in past 6 months	31%	36%	42%	42%	19%	36%

Table 20. Medical Care by SPECIAL POPULATIONS

	MCSM	MICA	Unstably housed
N	50	28	70
Ever seen doctor/med provider for HIV	100%	100%	99%
Have a current medical provider for HIV	96%	100%	91%
Gone to hospital clinic or OPD in past 6 months	64%	68%	62%
Gone to other medical clinic (ie community) past 6 mo	32%	21%	23%
Used mobile medical van past 6 months	0%	0%	0%
Gone to private medical provider past 6 months	22%	18%	10%
Received home health care past 6 months	8%	7%	4%
Received treatment adherence service past 6 months	59%	61%	55%
Seen dentist in past 6 months	68%	46%	51%
Seen alternative health provider / healer in past 6 months	8%	7%	4%
Stayed in nursing home, hospice, residential care for at least one night in past 6 months	4%	4%	1%
At least one in-patient stay in past 6 months	24%	36%	23%
At least one emergency room visit in past 6 months	42%	39%	36%

Table 21. Supportive Services by GENDER and RACE/ETHNICITY

Service	GENDER		RACE / ETHNICITY		
	Male	Female	White	Black	Latino
N	204	194	194	190	104
Food & Nutrition					
<i>Received counseling or group presentation past 6 mo</i>	37%	35%	31%	37%	40%
<i>Received meals in congregate setting past 6 mo</i>	32%	26%	28%	32%	26%
<i>Received home delivered meals past 6 mo</i>	13%	19%	8%	17%	20%
<i>Received food or food vouchers from pantry past 6 mo</i>	43%	52%	48%	48%	46%
<i>Needed help with food/groceries past 6 mo</i>	17%** *	34%	20%	26%	28%
<i>Received help with food/groceries past 6 mo</i>	15%	22%	27%	17%	14%
Case management					
<i>Received case mgmt past 6 mo</i>	71%	76%	73%	74%	74%
<i>Average number of case managers past 6 mo</i>	1.6	1.7	1.6	1.8	1.5
<i>CM revised or developed care plan past 6 mo</i>	57%**	73%	57%	66%	69%
<i>CM referred to specific med svces past 6 mo</i>	49%*	63%	47%	57%	62%
<i>CM referred to specific soc svces past 6 mo</i>	53%	54%	54%	54%	53%
<i>CM checked up on client past 6 mo</i>	75%	79%	83%	71%	82%
<i>CM assisted in forms & entitlements past 6 mo</i>	51%	54%	45%	52%	59%
<i>CM counseled about personal issues past 6 mo</i>	50%	59%	45%	49%	69%
<i>CM counseled about safer sex past 6 mo</i>	36%	31%	19%**	33%	47%
Client advocacy					
<i>Needed legal help past 6 mo</i>	11%	15%	16%	12%	12%
<i>Received legal help past 6 mo</i>	6%	6%	10%	6%	6%
Transportation					
<i>Needed transportation help past 6 mo</i>	18%*	26%	20%	21%	23%
<i>Received transportation svce past 6 mo</i>	10%	14%	12%	13%	12%
Child care					
<i>Needed child care past 6 mo</i>	1%***	8%	5%	6%	1%
<i>Received child care svce past 6 mo</i>	0%	2%	1%	1%	0%
Home care					
<i>Needed home care past 6 mo</i>	4%**	12%	9%	8%	8%
<i>Received home care svce past 6 mo</i>	3%	5%	7%	5%	1%

Table 22. Supportive Services by HEALTH PLANNING REGION

	SEast	SWest	WCent	NWest	ECent	NEast	Put	Rock
N	86	132	24	49	8	8	18	73
Food & Nutrition								
<i>Recvd individ or group counseling</i>	28%	44%	21%	19%	43%	13%	28%	52%
<i>Recvd meals in congregate setting</i>	27%	38%	42%	26%	14%	13%	28%	16%
<i>Recvd home delivered meals</i>	24%	16%	21%	17%	29%	13%	6%	6%
<i>Recvd food or vouchers from pantry</i>	36%	51%	38%	49%	14%	13%	56%	63%
<i>Needed help with food/groceries</i>	27%	27%	13%	31%	25%	25%	22%	21%
<i>Recvd help with food/groceries</i>	13%	18%	13%	23%	0%	13%	44%	19%
Case management								
<i>Recvd case mgmt</i>	69%	73%	67%	80%	88%	100%	89%	72%
<i>Average number of case managers</i>	1.6*	1.9	1.6	1.4	1.3	1.4	1.5	1.6
<i>CM revised or developed care plan</i>	62%	65%	75%	61%	50%	75%	69%	70%
<i>CM referred to specific med svces</i>	53%	54%	50%	53%	33%	63%	60%	67%
<i>CM referred to specific soc svces</i>	48%	53%	50%	50%	50%	50%	60%	65%
<i>CM checked up on client</i>	72%	74%	81%	68%	67%	88%	94%	89%
<i>CM assisted in forms & entitlements</i>	52%	48%	56%	47%	67%	63%	56%	61%
<i>CM counseled about personal issues</i>	50%	53%	69%	55%	67%	75%	63%	50%
<i>CM counseled about safer sex</i>	26%	37%	44%	37%	67%	38%	20%	28%
Client advocacy								
<i>Needed legal help</i>	12%	9%	8%	19%	38%	13%	22%	14%
<i>Recvd legal help</i>	2%	5%	4%	8%	13%	0%	6%	14%
Transportation								
<i>Needed transportation help</i>	20%	25%	17%	16%	25%	25%	44%	17%
<i>Recvd transportation svce</i>	10%	9%	13%	17%	13%	25%	28%	11%
Child care								
<i>Needed child care</i>	3%	4%	0%	6%	0%	13%	6%	6%
<i>Recvd child care svce</i>	1%	2%	0%	0%	0%	0%	0%	0%
Home care								
<i>Needed home care</i>	9%	8%	4%	12%	13%	0%	6%	7%
<i>Recvd home care svce</i>	6%	5%	0%	2%	13%	0%	6%	4%

Table 23. Supportive Services by RISK

	TOTAL	MSM	PDU	MSM + PDU	HETERO
N	398	60	157	18	147
Food & Nutrition					
<i>Recvd individ or group counseling</i>	36%	30%	39%	44%	34%
<i>Recvd meals in congregate setting</i>	29%	25%	30%	39%	29%
<i>Recvd home delivered meals</i>	16%	8%	20%	11%	16%
<i>Recvd food or vouchers from pantry</i>	47%	45%	49%	50%	46%
<i>Needed help with food/groceries</i>	25%	18%	23%	21%	31%
<i>Recvd help with food/groceries</i>	18%	13%	16%	26%	21%
Case management					
<i>Recvd case mgmt</i>	74%	76%	72%	84%	74%
<i>Average number of case managers</i>	1.7	1.7	1.7	1.6	1.6
<i>CM revised or developed care plan</i>	65%	58%	61%	88%	70%
<i>CM referred to specific med svces</i>	56%	44%	56%	69%	59%
<i>CM referred to specific soc svces</i>	53%	49%	54%	75%	52%
<i>CM checked up on client</i>	77%	78%	75%	94%	76%
<i>CM assisted in forms & entitlements</i>	52%	51%	52%	69%	51%
<i>CM counseled about personal issues</i>	54%	51%	54%	63%	56%
<i>CM counseled about safer sex</i>	33%	31%	40%	25%	29%
Client advocacy					
<i>Needed legal help</i>	13%	13%*	7%	21%	18%
<i>Recvd legal help</i>	6%	6%	4%	16%	8%
Transportation					
<i>Needed transportation help</i>	22%	19%	20%	37%	23%
<i>Recvd transportation svce</i>	12%	10%	12%	16%	13%
Child care					
<i>Needed child care</i>	4%	0%	2%	6%	9%
<i>Recvd child care svce</i>	1%	0%	0%	0%	2%
Home care					
<i>Needed home care</i>	8%	3%	10%	0%	9%
<i>Recvd home care svce</i>	4%	3%	5%	0%	5%

Table 24. Supportive Services by RISK & RACE/ETHNICITY

	MSM	PDU		MSM + PDU	HETERO	
		Male	Female		Male	Female
N	62	85	79	19	38	115
Food & Nutrition						
<i>Recvd individ or group counseling</i>	30%	42%	37%	44%	33%	34%
<i>Recvd meals in congregate setting</i>	25%	38%	22%	39%	25%	30%
<i>Recvd home delivered meals</i>	8%	16%	23%	11%	14%	16%
<i>Recvd food or vouchers from pantry</i>	45%	43%	55%	50%	36%	50%
<i>Needed help with food/groceries</i>	18%	14%	33%	21%	19%	35%
<i>Recvd help with food/groceries</i>	13%	13%	19%	26%	16%	23%
Case management						
<i>Recvd case mgmt</i>	76%	65%	80%	84%	73%	74%
<i>Average number of case managers</i>	1.7	1.6	1.8	1.6	1.5	1.7
<i>CM revised or developed care plan</i>	58%	50%	71%	88%	52%	75%
<i>CM referred to specific med svcs</i>	44%	53%	58%	69%	36%	66%
<i>CM referred to specific soc svcs</i>	49%	53%	55%	75%	48%	54%
<i>CM checked up on client</i>	78%	67%	82%	94%	76%	76%
<i>CM assisted in forms & entitlements</i>	51%	50%	53%	69%	40%	55%
<i>CM counseled about personal issues</i>	51%	50%	56%	62%	40%	61%
<i>CM counseled about safer sex</i>	31%	43%	37%	25%	36%	26%
Client advocacy						
<i>Needed legal help</i>	13%	5%	10%	21%	16%	18%
<i>Recvd legal help</i>	6%	4%	4%	16%	8%	8%
Transportation						
<i>Needed transportation help</i>	19%	13%	27%	37%	16%	25%
<i>Recvd transportation svce</i>	10%	11%	13%	16%	8%	14%
Child care						
<i>Needed child care</i>	0%	0%	4%	5%	0%	11%
<i>Recvd child care svce</i>	0%	0%	0%	0%	0%	3%
Home care						
<i>Needed home care</i>	3%	6%	14%	0%	5%	11%
<i>Recvd home care svce</i>	3%	5%	5%	0%	3%	5%

Table 25. Supportive Services by SPECIAL POPULATIONS

	MCSM	MICA	Unstably housed
N	50	28	70
Food & Nutrition			
<i>Recvd individ or group counseling</i>	38%	32%	30%
<i>Recvd meals in congregate setting</i>	32%	57%**	32%
<i>Recvd home delivered meals</i>	11%	36%**	14%
<i>Recvd food or vouchers from pantry</i>	47%	57%	39%
<i>Needed help with food/groceries</i>	22%	39%	28%
<i>Recvd help with food/groceries</i>	12%	25%	12%
Case management			
<i>Recvd case mgmt</i>	82%	79%	78%
<i>Average number of case managers</i>	1.7	2.0*	1.6*
<i>CM revised or developed care plan</i>	69%	68%	58%
<i>CM referred to specific med svces</i>	59%	73%	50%
<i>CM referred to specific soc svces</i>	62%	55%	52%
<i>CM checked up on client</i>	82%	82%	68%
<i>CM assisted in forms & entitlements</i>	62%	59%	56%
<i>CM counseled about personal issues</i>	59%	59%	48%
<i>CM counseled about safer sex</i>	33%	41%	36%
Client advocacy			
<i>Needed legal help</i>	14%	11%	19%
<i>Recvd legal help</i>	6%	7%	8%
Transportation			
<i>Needed transportation help</i>	26%	36%	20%
<i>Recvd transportation svce</i>	12%	18%	10%
Child care			
<i>Needed child care</i>	0%	4%	0%
<i>Recvd child care svce</i>	0%	4%	0%
Home care			
<i>Needed home care</i>	2%	21%**	8%
<i>Recvd home care svce</i>	2%	7%	1%

Table 26. Substance Abuse & Mental Health by GENDER and RACE/ETHNICITY

Service	GENDER		RACE / ETHNICITY		
	Male	Female	White	Black	Latino
N	204	194	82	197	110
Substance Abuse Treatment					
Ever wanted tx, unable to get in to (waiting list, restric)	11%	11%	12%	10%	14%
Last 6 month wanted tx, unable to get in to	21%	19%	25%	20%	18%
Specific barriers to getting in to drug treatment program					
<i>Waiting list</i>	4%	2%	4%	3%	3%
<i>No child care</i>	0%	1%	0%	1%	1%
<i>No openings for women</i>	0%	1%	1%	0%	0%
<i>Transportation problems</i>	0%	0%	0%	0%	0%
<i>Other logistical problems</i>	0%	1%	0%	0%	1%
<i>Sobriety/abstinence was a requirement</i>	4%	5%	9%	4%	3%
Ever received any type of drug treatment	52%	59%	36%**	61%	59%
Importance now of further drug treatment...					
<i>Not at all important</i>	59%	52%	62%	55%	52%
<i>Slightly important</i>	7%	3%	10%	2%	7%
<i>Moderately important</i>	3%	6%	3%	6%	4%
<i>Considerably important</i>	2%	4%	0%	3%	6%
<i>Extremely important</i>	30%	33%	25%	34%	31%
Psychosocial support					
<i>Needed help with emotional/psych issue past 6 mo</i>	13%*	22%	28%**	11%	23%
<i>Received professional mental health svce in past 6 mo</i>	23%	22%	35%**	15%	25%
<i>Received supportive mental health svce in past 6 mo</i>	31%	33%	40%	27%	35%

Table 27. Substance Abuse & Mental Health by HEALTH PLANNING REGION

	SEast	SWest	WCent	NWest	ECent	NEast	Put	Rock
N	86	132	24	49	8	8	18	73
Substance Abuse Treatment								
Ever wanted tx, unable to get in to (waiting list, restric)	3%	16%	17%	7%	0%	0%	20%	15%
Last 6 month wanted tx, unable to get in to	0%	6%*	67%	67%	0%	0%	0%	29%
Specific barriers to getting in to drug treatment program	0%	0%	0%	0%	0%	0%	0%	0%
<i>Waiting list</i>	2%	3%	13%	2%	0%	0%	6%	1%
<i>No child care</i>	0%	1%	0%	0%	0%	0%	0%	1%
<i>No openings for women</i>	0%	0%	0%	0%	0%	0%	0%	1%
<i>Transportation problems</i>	0%	0%	0%	0%	0%	0%	0%	0%
<i>Other logistical problems</i>	0%	0%	0%	0%	0%	0%	0%	1%
<i>Sobriety/abstinence was a requirement</i>	1%	4%	8%	4%	0%	0%	11%	8%
Ever received any type of drug tx	58%	56%	39%	59%	33%	43%	41%	63%
Importance now of further drug treatment...								
<i>Not at all important</i>	63%	50%	78%	52%	83%	71%	47%	50%
<i>Slightly important</i>	6%	5%	0%	7%	0%	0%	0%	8%
<i>Moderately important</i>	4%	7%	0%	5%	0%	0%	12%	2%
<i>Considerably important</i>	1%	3%	0%	7%	0%	14%	0	4%
<i>Extremely important</i>	25%	35%	22%	30%	17%	14%	41%	35%
Psychosocial support								
<i>Needed help with emotional/psych issue past 6 mo</i>	9%**	21%	13%	27%	25%	25%	44%	8%
<i>Received professional mental health svce in past 6 mo</i>	9%***	27%	25%	33%	25%	50%	44%	11%
<i>Received supportive mental health svce in past 6 mo</i>	24%**	33%	33%	47%	25%	38%	67%	21%

Table 28. Substance Abuse & Mental Health by RISK

	TOTAL	MSM	PDU	MSM + PDU	HETERO
N	398	62	164	19	153
Substance Abuse Treatment					
Ever wanted tx, unable to get in to (waiting list, restric)	11%	0%	16%*	13%	9%
Last 6 month wanted tx, unable to get in to	20%	0%	16%	0%	38%
Specific barriers to getting in to drug treatment program					
<i>Waiting list</i>	3%	0%	6%*	5%	1%
<i>No child care</i>	1%	0%	1%	0%	0%
<i>No openings for women</i>	1%	0%	1%	0%	0%
<i>Transportation problems</i>	0%	0%	0%	0%	0%
<i>Other logistical problems</i>	1%	0%	1%	0%	0%
<i>Sobriety/abstinence was a requirement</i>	5%	0%	7%	5%	4%
Ever received any type of drug treatment	55%	22%***	78%	71%	31%
Importance now of further drug treatment...					
<i>Not at all important</i>	56%	67%*	46%	35%	70%
<i>Slightly important</i>	5%	6%	4%	12%	4%
<i>Moderately important</i>	5%	2%	6%	6%	4%
<i>Considerably important</i>	3%	0%	5%	0%	2%
<i>Extremely important</i>	31%	24%	39%	47%	19%
Psychosocial support					
<i>Needed help with emotional/psych issue past 6 mo</i>	18%	16%	18%	21%	17%
<i>Received professional mental health svce in past 6 mo</i>	22%	19%	24%	32%	20%
<i>Received supportive mental health svce in past 6 mo</i>	32%	31%	37%	37%	27%

Table 29. Substance Abuse & Mental Health by RISK & RACE/ETHNICITY

	MSM	PDU		MSM + PDU	HETERO	
		Male	Female		Male	Female
N	62	85	79	19	38	115
Substance Abuse Treatment						
Ever wanted tx, unable to get in to (waiting list, restric)	0%	19%*	13%	13%	8%	9%
Last 6 month wanted tx, unable to get in to	0%	20%	10%	0%	50%	33%
Specific barriers to getting in to drug treatment program						
<i>Waiting list</i>	0%	8%*	4%	5%	0%	1%
<i>No child care</i>	0%	0%	3%	0%	0%	0%
<i>No openings for women</i>	0%	0%	1%	0%	0%	0%
<i>Transportation problems</i>	0%	0%	0%	0%	0%	0%
<i>Other logistical problems</i>	0%	0%	1%	0%	0%	0%
<i>Sobriety/abstinence was a requirement</i>	0%	8%	5%	5%	3%	4%
Ever received any type of drug treatment	22%** *	72%	85%***	71%	36%	29%
Importance now of further drug treatment...						
<i>Not at all important</i>	67%	53%	38%*	35%	76%	68%
<i>Slightly important</i>	6%	5%	4%	12%	8%	3%
<i>Moderately important</i>	2%	4%	8%	6%	4%	5%
<i>Considerably important</i>	0%	4%	6%	0%	0%	3%
<i>Extremely important</i>	24%	35%	44%	47%	12%	21%
Psychosocial support						
<i>Needed help with emotional/psych issue past 6 mo</i>	16%	11%	27%	21%	11%	19%
<i>Received professional mental health svce in past 6 mo</i>	19%	20%	29%*	32%	29%	17%
<i>Received supportive mental health svce in past 6 mo</i>	31%	35%	39%	37%	21%	29%

Table 30. Substance Abuse & Mental Health by SPECIAL POPULATIONS

	MCSM	MICA	Unstably housed
N	50	28	70
Substance Abuse Treatment			
Ever wanted tx, unable to get in to (waiting list, restric)	5%	18%	13%
Last 6 month wanted tx, unable to get in to	0%	40%	57%**
Specific barriers to getting in to drug treatment program			
<i>Waiting list</i>	2%	4%	3%
<i>No child care</i>	0%	0%	0%
<i>No openings for women</i>	0%	0%	0%
<i>Transportation problems</i>	0%	0%	0%
<i>Other logistical problems</i>	0%	0%	0%
<i>Sobriety/abstinence was a requirement</i>	2%	11%	7%
Ever received any type of drug treatment	41%	71%	60%
Importance now of further drug treatment...			
<i>Not at all important</i>	56%	43%*	55%
<i>Slightly important</i>	7%	4%	4%
<i>Moderately important</i>	2%	18%	4%
<i>Considerably important</i>	0%	4%	4%
<i>Extremely important</i>	34%	32%	34%
Psychosocial support			
<i>Needed help with emotional/psych issue past 6 mo</i>	12%	46%***	10%
<i>Received professional mental health svce in past 6 mo</i>	22%	36%	26%
<i>Received supportive mental health svce in past 6 mo</i>	34%	50%*	33%

Table 31. Housing & Financial Needs by GENDER and RACE/ETHNICITY

Service	GENDER		RACE / ETHNICITY		
	Male	Female	White	Black	Latino
N	204	194	82	197	110
Housing					
Current living situation...					
<i>Apt or house – owned</i>	13%*	8%	21%**	6%	10%
<i>Apt or house – rented</i>	60%	76%	67%	71%	64%
<i>Doubled up with friend of family</i>	8%	6%	4%	7%	10%
<i>SRO or welfare hotel/motel</i>	1%	1%	0%	3%	0%
<i>Specialized AIDS housing</i>	7%	4%	2%	6%	7%
<i>Drug treatment program housing</i>	2%	0%	0%	2%	0%
<i>Shelter</i>	2%	2%	1%	2%	2%
<i>Street or other public place</i>	0%	0%	0%	0%	0%
<i>Hospital, nursing home, hospice</i>	2%	2%	1%	3%	2%
<i>Jail, prison, halfway house</i>	0%	1%	1%	0%	0%
<i>Mobile home</i>	0%	0%	0%	0%	0%
<i>Other</i>	4%	1%	2%	1%	5%
Current HIV/AIDS housing is...					
<i>Temporary or transition housing</i>	17%	18%	0%	24%	10%
<i>Congregate living facility</i>	61%	45%	50%	41%	80%
<i>Scatter site apartment program</i>	17%	27%	50%	24%	10%
<i>Other</i>	6%	9%	0%	12%	0%
Housing assistance					
<i>Needed help with housing in past 6 mo</i>	34%*	45%	27%*	42%	44%
<i>Received help with housing in past 6 mo</i>	12%	18%	16%	15%	15%
Financial Need					
<i>Needed help with financial matters past 6 mo</i>	34%**	49%	40%	40%	42%
<i>Received help with financial matters in past 6 mo</i>	5%**	13%	18%**	8%	6%

Table 32. Housing & Financial Needs by HEALTH PLANNING REGION

	SEast	SWest	WCent	NWest	ECent	NEast	Put	Rock
N	86	132	24	49	8	8	18	73
Housing								
Current living situation...								
<i>Apt or house – owned</i>	6%***	8%	17%	18%	0%	25%	28%	10%
<i>Apt or house – rented</i>	77%	62%	50%	65%	75%	50%	67%	78%
<i>Doubled up with friend of family</i>	8%	5%	13%	10%	13%	0%	0%	7%
<i>SRO or welfare hotel/motel</i>	2%	0%	0%	4%	0%	0%	0%	1%
<i>Specialized AIDS housing</i>	0%	14%	8%	0%	0%	0%	0%	0%
<i>Drug treatment program housing</i>	1%	2%	0%	0%	0%	13%	0%	0%
<i>Shelter</i>	2%	1%	4%	2%	13%	13%	0%	0%
<i>Street or other public place</i>	0%	0%	0%	0%	0%	0%	0%	0%
<i>Hospital, nursing home, hospice</i>	0%	5%	0%	0%	0%	0%	0%	1%
<i>Jail, prison, halfway house</i>	1%	0%	0%	0%	0%	0%	0%	0%
<i>Mobile home</i>	0%	0%	0%	0%	0%	0%	0%	0%
<i>Other</i>	2%	2%	8%	0%	0%	0%	6%	3%
Current HIV/AIDS housing is...								
<i>Temporary or transition housing</i>	0%	15%	50%	0%	0%	0%	0%	0%
<i>Congregate living facility</i>	0%	62%	0%	0%	0%	0%	0%	0%
<i>Scatter site apartment program</i>	0%	15%	50%	0%	0%	0%	0%	100%
<i>Other</i>	0%	8%	0%	0%	0%	0%	0%	0%
Housing assistance								
<i>Needed help with housing in past 6 mo</i>	44%	37%	25%	41%	63%	38%	17%	44%
<i>Received help with housing in past 6 mo</i>	13%	17%	13%	10%	25%	0%	22%	17%
Financial Need								
<i>Needed help with financial matters past 6 mo</i>	36%	37%	46%	47%	38%	50%	56%	44%
<i>Received help with financial matters in past 6 mo</i>	7%**	8%	8%	4%	13%	13%	39%	10%

Table 33. Housing & Financial Needs by RISK

	TOTAL	MSM	PDU	MSM + PDU	HETERO
N	398	62	164	19	153
Housing					
Current living situation...					
<i>Apt or house – owned</i>	11%	13%**	10%	21%	10%
<i>Apt or house – rented</i>	68%	63%	69%	42%	73%
<i>Doubled up with friend of family</i>	7%	10%	5%	5%	9%
<i>SRO or welfare hotel/motel</i>	1%	0%	2%	0%	1%
<i>Specialized AIDS housing</i>	5%	10%	5%	5%	3%
<i>Drug treatment program housing</i>	1%	0%	1%	11%	1%
<i>Shelter</i>	2%	0%	3%	0%	1%
<i>Street or other public place</i>	0%	0%	0%	0%	0%
<i>Hospital, nursing home, hospice</i>	2%	0%	2%	11%	1%
<i>Jail, prison, halfway house</i>	1%	0%	0%	0%	1%
<i>Mobile home</i>	0%	0%	0%	0%	0%
<i>Other</i>	3%	5%	2%	5%	1%
Current HIV/AIDS housing is...					
<i>Temporary or transition housing</i>	17%	0%	20%	100%	17%
<i>Congregate living facility</i>	55%	71%	47%	0%	67%
<i>Scatter site apartment program</i>	21%	29%	27%	0%	0%
<i>Other</i>	7%	0%	7%	0%	17%
Housing assistance					
<i>Needed help with housing in past 6 mo</i>	39%	31%	39%	26%	44%
<i>Received help with housing in past 6 mo</i>	15%	10%	19%	11%	14%
Financial Need					
<i>Needed help with financial matters past 6 mo</i>	41%	31%*	41%	21%	48%
<i>Received help with financial matters in past 6 mo</i>	9%	6%	7%	5%	13%

Table 34. Housing & Financial Needs by RISK & RACE/ETHNICITY

	MSM	PDU		MSM + PDU	HETERO	
		Male	Female		Male	Female
N	62	85	79	19	38	115
Housing						
Current living situation...						
<i>Apt or house – owned</i>	13%	9%	10%	21%	18%	7%
<i>Apt or house – rented</i>	63%	65%	73%	42%	55%	78%
<i>Doubled up with friend of family</i>	10%	5%	5%	5%	13%	7%
<i>SRO or welfare hotel/motel</i>	0%	4%	1%	0%	0%	1%
<i>Specialized AIDS housing</i>	10%	6%	5%	5%	5%	3%
<i>Drug treatment program housing</i>	0%	1%	0%	11%	3%	0%
<i>Shelter</i>	0%	4%	3%	0%	3%	1%
<i>Street or other public place</i>	0%	0%	0%	0%	0%	0%
<i>Hospital, nursing home, hospice</i>	0%	4%	1%	11%	0%	2%
<i>Jail, prison, halfway house</i>	0%	0%	0%	0%	0%	1%
<i>Mobile home</i>	0%	0%	0%	0%	0%	0%
<i>Other</i>	5%	4%	1%	5%	3%	1%
Current HIV/AIDS housing is...						
<i>Temporary or transition housing</i>	0%	25%	14%	100%	0%	25%
<i>Congregate living facility</i>	71%	50%	43%	0%	100%	50%
<i>Scatter site apartment program</i>	29%	13%	43%	0%	0%	0%
<i>Other</i>	0%	13%	0%	0%	0%	25%
Housing assistance						
<i>Needed help with housing in past 6 mo</i>	31%	35%	43%	26%	38%	46%
<i>Received help with housing in past 6 mo</i>	10%	17%	21%	11%	5%	17%
Financial Need						
<i>Needed help with financial matters past 6 mo</i>	31%	33%	51%	21%	49%	47%
<i>Received help with financial matters in past 6 mo</i>	6%	6%	8%	5%	3%	17%

Table 35. Housing & Financial Needs by SPECIAL POPULATIONS

	MCSM	MICA	Unstably Housed
N	50	28	70
Housing			
Current living situation...			
<i>Apt or house – owned</i>	10%	11%	0%
<i>Apt or house – rented</i>	56%	61%	29%***
<i>Doubled up with friend of family</i>	12%	7%	40%
<i>SRO or welfare hotel/motel</i>	0%	4%	7%
<i>Specialized AIDS housing</i>	10%	11%	4%
<i>Drug treatment program housing</i>	4%	0%	6%
<i>Shelter</i>	0%	0%	10%
<i>Street or other public place</i>	0%	0%	0%
<i>Hospital, nursing home, hospice</i>	4%	0%	0%
<i>Jail, prison, halfway house</i>	0%	0%	1%
<i>Mobile home</i>	0%	0%	0%
<i>Other</i>	4%	7%	3%
Current HIV/AIDS housing is...			
<i>Temporary or transition housing</i>	17%	0%	50%
<i>Congregate living facility</i>	67%	67%	25%
<i>Scatter site apartment program</i>	17%	33%	25%
<i>Other</i>	0%	0%	0%
Housing assistance			
<i>Needed help with housing in past 6 mo</i>	32%	54%	62%***
<i>Received help with housing in past 6 mo</i>	6%	29%*	16%
Financial Need			
<i>Needed help with financial matters past 6 mo</i>	28%*	61%*	46%
<i>Received help with financial matters in past 6 mo</i>	4%	4%	3%*

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 32 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 in Creole.

GLOSSARY OF TERMS

AIDS Institute (AI) criteria for care—AI criteria for appropriate medical care for HIV+ persons consists of: 1) required number of medical care visits (further contingent upon T-cell count and antiretroviral use); 2) self-reported complete physical and blood work; and 3) self-reported T-cell count.

AOD—Alcohol and other drugs.

Barriers to care—Barriers to care (lack of information) were established via questions such as: “Did you ever delay or not get assistance you thought you needed” because “you didn’t know or weren’t sure where to go” for medical or social services?

Comprehensive medical care—Respondents were considered to receive comprehensive medical care if they responded “yes” to the following three questions: Is your routine medical provider someone you can go to for (1) “routine check-ups,” (2) “information or advice about a health concern” and (3) “someone you could call up 24 hours a day in case of a medical emergency?”

Cultural/language barriers to care—Established via the following questions: “Did you ever delay or not get assistance you thought you needed” because the staff “. . . Do not speak your language? . . . Are not competent to deal with your problem? . . . Are often not polite, disrespectful or insensitive to your needs?” Are you not sure that they “. . . would understand your problems?” or are “not good at listening to your problems or needs?”

Help with taking meds—Established via responses to the question: “Has anyone suggested ways to help you take your medicine on time and in the right way?”

Hetero—HIV risk group for persons who risk exposure to the virus via heterosexual contact.

MSM—Men who have sex with men.

Objective need for mental health services—Established by a score of less than 37.0 on the Mental Health Component Summary score of the SF-36, developed by the MOS.

PCS score—Physical Component Summary score of the SF-36, developed by the MOS. Scores of 45 and above are considered “high.”

PDU—Problem drug users, who have used cocaine, crack or heroin three or more times a week for a month or more, or who have ever had a serious alcohol problem, or who have ever injected drugs.

Professional mental health services—Mental health services provided by a psychiatrist or psychologist.

Supportive mental health services—Mental health services such as counseling provided by a case manager, clergy, etc.

Unstable housing—Any episode of living in the street, a shelter, a single-room occupancy, or doubled up with a friend or relative in past 6 months.