

Initial Needs Assessment for New York City

2002



Prepared for the HIV Health and Human Services Planning Council of New York
under the direction of the New York City Office of the Mayor/AIDS Policy Coordination

Prepared by McClain and Associates, Inc.

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Acknowledgments

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Guide to Readers

A. Purpose

The purpose of a needs assessment is to define and describe service needs as well as gaps in services for people with HIV disease. This enables planning, priority-setting, and allocation of resources in local communities. In the context of HIV/AIDS funding, one objective of a needs assessment is to assure that Federal CARE Act Title I funding is targeted where it is most needed. HIV/AIDS needs assessments also draw a comprehensive picture of an area's needs so that all resources can be spent in the most effective manner.

This needs assessment was commissioned by the HIV Health and Human Services Planning Council of New York. It partially satisfies the mandates of the CARE Act Amendments of 2000 requiring each Title I planning council to assess needs and develop comprehensive plans for the organization and delivery of HIV/AIDS services. This document is one of several that make up the current effort in New York to develop its *Comprehensive Strategic Plan for HIV/AIDS Service 2002-2005*, which is scheduled to be issued in the fall of 2002.

The New York City Mayor's Office/AIDS Policy Coordination (MO/APC) oversees the entire planning process, including this needs assessment. MO/APC provides professional and administrative support to the Planning Council, which sets priorities and allocates CARE Act Title I funds. Title I funds are granted by the Federal government to eligible metropolitan areas (EMAs) that are disproportionately affected by the HIV/AIDS epidemic. Funding is to support the provision of care and treatment services. The New York EMA consists of New York City and the counties of Westchester, Rockland, and Putnam (known as the "Tri-County Region"). A separate needs assessment document has been prepared for the Tri-County Region.

Title I grants are awarded to the chief elected official of the city or county that administers the public health agency providing services to the greatest number of people with AIDS in the area. In the New York EMA, the Title I grant is awarded to the Mayor of New York City. Consistent with the CARE Act Amendments of 2000, the Planning Council is responsible for establishing the service priorities to which Title I funds are allocated within the New York EMA.

The Planning Council will use this needs assessment as the base of evidence to develop a plan consisting of goals, objectives, and mechanisms to monitor the plan. The

Planning Council conducts much of the detail work of planning through the Planning and Evaluation Committee, the Executive Committee, six Work Groups, additional input from subcommittees, planning groups, and the PWA Advisory Group.

B. Methods

The needs assessment was designed to be consistent with the CARE Act Amendments of 2000, Federal guidance as promulgated by the Health Resources and Services Administration (HRSA), and local circumstances. The major elements of the needs assessment are:

- *An epidemiological profile* that describes the current status of the epidemic in New York City, specifically the prevalence of HIV and AIDS among defined sub-populations. The profile also identifies trends.
- *An assessment of service needs* among the affected populations that explores the perspectives of people living with HIV (PLWH), providers, researchers, and community representatives about service needs.
- *A resource inventory* that describes organizations providing services across the continuum of care. This inventory develops a comprehensive picture of services, regardless of funding source.
- *A profile of provider capacity and capability* that shows the extent to which services identified in the resource inventory are accessible, available, and appropriate for PLWH.
- *An assessment of gaps in services* that brings together data on service needs, resources, and barriers to help set priorities and allocate resources.

Needs assessments, as with all health services planning, are not completely precise processes. Even the most comprehensive and rigorous needs assessment have missing or even conflicting information. It is the responsibility of the Planning Council to apply its best effort, wisdom, and judgment in considering all the information that is available to its members in defining gaps, developing goals and objectives, and setting priorities.

This needs assessment was developed using a variety of methods and types of data. We gathered and analyzed quantitative and qualitative data drawn from a wide range of existing data sources. Indeed, a large volume of source material was condensed into a manageable collection of essential needs assessment data that are presented in the sections which follow. Nearly 130 documents were gathered and thousands of pages analyzed. Not every item that resulted from this process easily fit into one of these definitions, so readers may find some overlap. See Section 2, Sources (below) for more information on how the documents were used to develop the needs assessment.

C. How to use this document

The needs assessment is a tool. It is designed to be flexible and capable of being augmented as the planning process unfolds. Its structure and organization was drawn from HRSA guidance and technical assistance materials, from the most recent needs assessment developed by the Planning Council (the 1997 *Comprehensive Planning Tool*), input from the New York City Department of Health and MHRA, and from direction provided by the MO/APC.

As was the case with its 1997 predecessor, the current needs assessment is intended to provide each Planning Council Work Group with a common base of evidence for use in its later planning decision-making. Despite being designed with the processes of Work Groups in mind, certain specific planning questions may not be able to be fully answered by the needs assessment. Identification and examination of relevant source materials – or use of new source materials -- can occur throughout the planning process at the request of the Work Groups.

Certain definitions are important to keep in mind:

Quantitative data: numbers that can be statistically analyzed and are used to describe what, who, when, how many, or how much in relation to a question or issue.

Qualitative data: descriptive information usually presented in narrative form. Qualitative data can help illuminate what is happening, as well as describe how or why something is occurring.

Special needs: Broad descriptions of the population and its unique cultural and/or service needs.

Targeted services: Services that exist within the continuum of care in order to meet the unique needs of this population.

Service utilization: Qualitative or quantitative data that describes the service utilization patterns of a population.

Disparities: Differences, primarily in longer-term health outcomes, between different populations or geographic regions.

Gaps: A perceived (qualitative) or measurable lack of availability or appropriateness of services or concrete needs.

Barriers: Impediments in access to care, including structural (availability, how organized, transportation), financial (insurance coverage, reimbursement levels, public support), and personal (acceptability, cultural, language, attitudes, education/income).

Overcoming barriers: Strategies, usually programmatic, that could potentially help to overcome barriers.

Outcomes: Defined as longer-term outcomes, such as improved health status, versus intermediate outcomes, such as service utilization rates. Client satisfaction and service quality measures are also included in this category.

It is the responsibility of the Planning Council and its Work Groups to determine the meaning of the data contained in this needs assessment. In doing so, it is important to carefully consider the data gaps presented in Section 8, below. However, some broad themes and general trends can be stated as a basic framework for readers of this document:

- Persons with HIV/AIDS who seek care and services can get them in New York City.
- Housing is a significant unmet or partially unmet need in New York City for people living with HIV/AIDS.
- The actual number of people living with HIV infection (as distinguished from the smaller number of people with reported cases of AIDS) remains unknown. However, a very large number of individuals with HIV disease (HIV infection and AIDS) and their families reside in New York City and seek HIV/AIDS care and support services.
- A large amount of qualitative and quantitative data are available on the characteristics and needs of the populations of people living with HIV/AIDS in New York City, but certain data gaps also exist.

Table 1 helps readers locate tables in the needs assessment that may help them find answers to some specific planning related questions.

Table 1. Guide To Readers

FREQUENTLY ASKED QUESTIONS	WHERE TO LOOK
A	B
1. Where can I find basic information on the number of AIDS cases and their demographics?	Figures 1-8, pages 28-36 Table 4, page 41
2. Where can I find general population information?	Table 3, pages 28-39
3. Where do I go to find needs identified by people living with HIV/AIDS?	Table 14, pages 118-135
4. Which tables present information on specific populations affected by HIV?	Table 5, pages 43-63 Table 7, pages 69-75, Table 8, page 76 Table 9, page 77 Table 12, pages 97-107 Table 13, pages 108-113 Table 15, pages 136-138
5. Which tables present information on HIV/AIDS services?	Table 7, pages 69-75 Table 8, page 76 Table 9, page 77 Table 10, pages 88-90 Table 14, pages 118-135
6. Which tables and maps present information on boroughs?	Table 10, pages 88-90 Figure 8, pages 34-36 Figure 9, pages 82-87
7. Where do I look for information on barriers and strategies to overcome them?	Table 12, pages 97-107
8. Where do I look for information on gaps?	Table 14, pages 118-135
9. Where do I look for information on funding?	Table 10, pages 88-90 Table 11, page 91
10. Where do I look for information on outcomes?	Table 13, pages 108-113
11. Where can I find information on persons unconnected to HIV care, including persons who are aware of their HIV status?	Table 15, pages 136-138 Table 16, pages 139-142

Sources

This section lists all the sources used for developing this needs assessment.¹

The Office of the Mayor/AIDS Policy Coordination, the New York City Department of Health, and MHRA provided many of the documents. In addition, the Planning Council work groups, planning committees, as well as the PLWA Advisory Group were invited to review an initial roster of documents and provide additional contributions.

Every document was given a unique code number and assigned to a member of the project team. In addition, all team members reviewed certain key documents. Every document was studied for its relevance to the needs assessment and planning process. An abstract was then written for each document using a common format. Relevant and useful information was noted, such as the page number on which a specific item appears. A database containing all the abstracts was then developed. Outputs from this database on key subjects, such as specific populations and service categories, were then used to develop the tables and narrative of this needs assessment.²

Throughout the document, readers will find sources referenced using the unique code number that appears in column A of Table 2, below. In addition, the specific page number of that document is cited. This is intended to give the reader the ability to locate specific objective evidence for future planning-related decision-making.

For example, Table 14 includes this entry: "89:ES. In a 1998 Montefiore study 64% of survey respondents reported a serious delay or total inability to access needed dental care." The reader can location row 89 on this table to find out the full title of the study and the date it was published: "Needs Assessment and Service Utilization Study of Dental Care for HIV Infected Persons," December 2001. The "ES" part of the entry indicates the data are found in the report's Executive Summary. Normally, this would be a number (such as "89:45"), indicating the information can be found on page number 45 of document 89.

¹ Through March 1, 2002

² The database of abstracts is available for future planning questions.

Table 2. Sources by Abstract Code Number

Code #	Title Date	Source/ Authors
A	B	C
001	The Epidemiology of AIDS in New York City December 2001	New York City Department of Health (DOH), HIV/AIDS Surveillance
002	AIDS Surveillance Update for the Fourth Quarter 2000 June 2001	DOH HIV/AIDS Surveillance
003	New York City Children Perinataly Exposed to HIV, Semiannual Surveillance Update May 2001	DOH HIV/AIDS Surveillance
004	AIDS Surveillance Update for the First Quarter 2000 June 2000	DOH HIV/AIDS Surveillance
005	HIV Seroprevalence Update 1999	DOH AIDS Research/HIV Serosurvey Program
006	NYC epi data by zip code Judy Sackoff	DOH
007	ADAP Plus data	NYSDOH
008	Medicaid claims data	NYSDOH
009	Quarterly Performance Report October 2000-December 2000	NYC HRA DASIS
010	Review of 1998-2001 Strategic Plan	Team
011	NY EMA FY 2002 Title I Application	DOH
012	NY EMA FY 2001 Title I Application	DOH
013	New York City Ryan White Title I CARE Act Service Directory June 2000	MHRA
014	Title I Program Services Internet 1999 http://nyc.gov/html/doh/html/rw/rw4.html	DOH

Code #	Title Date	Source/ Authors
A	B	C
015	NYC Ryan White Title I Service Directory Program Services by Agency http://nyc.gov/html/doh/html/re/rwa.html	DOH
016	New York Statewide Coordinated Statement of Need December 1997	NYSDOH SRA
017	Community Health Advisory & Information Network (CHAIN) Fact Sheet October 2000	Columbia
018	CHAIN Report #44: Drug Use and Service Utilization Among People with HIV in NYC: Barriers to Care and Low Threshold Services December 2001	Columbia
019	CHAIN Maps: Update Report #42, A Geographic Display of the CHAIN Cohort's Service Utilization May 2001, Revised December 2001	Columbia
020	CHAIN Report Update #39: Trends in Health Status September 2001	Columbia
021	CHAIN Report Update #38: Ancillary Services and Adherence to HIV Medications October 2001	Columbia
022	Housing, Health and Wellness Study: A Collaborative Project October 2000	Columbia and Bailey House
023	CHAIN Report #37: Housing and Health Care Among Persons Living with HIV/AIDS July 2001	Columbia
024	CHAIN Report Update #36: Pathways to Systems of HIV Medical Care in New York City October 2001	Columbia

Table 2 *continued**Sources by Abstract
Code Number*

Table 2 *continued**Sources by Abstract
Code Number*

Code #	Title Date	Source/ Authors
A	B	C
025	CHAIN Update Report #35: Assessing the Impact of the Ryan White CARE Act on Health Outcomes in New York City: Executive Summary (Revised Draft) November 2001	Columbia
026	CHAIN Update Report #34: Medication Adherence and Patient Outcomes November 2001	Columbia
027	CHAIN Update Report #33: Dental Services for HIV+ Individuals in New York City's CHAIN Cohort March 2001	Columbia
028	CHAIN Update Report #32: Housing Assistance and Housing Stability Among Persons Living with HIV/AIDS May 2000	Columbia
029	CHAIN Update Report #30: The Impact of Ancillary Services on Entry and Retention to HIV Medical Care in New York City Date?	Columbia
030	CHAIN Update Report #29: Mental Health Services and Treatment Needs June 2000	Columbia
031	CHAIN Briefing Papers for Year 9 CHAIN Reports May 2000 [Update Report #s 23, 24, 25, 26, 27, 28, 30, 32 Technical Report #16 Rapid Response Report #2]	Columbia
032	CHAIN Project [Overview] 2000?	Columbia
033	CHAIN Update Report #28: Women's Need and Utilization of Services by Family Types June 2000	Columbia

Code #	Title Date	Source/ Authors
A	B	C
034	CHAIN Update Report #27: Complementary and Alternative Medicine: Rates of Utilization Among the CHAIN Cohort May 2000	Columbia
035	CHAIN Update Report #26: Declining Mortality Rates and Service Interventions April 2000	Columbia
036	CHAIN Update Report #25: Factors Influencing Interest in Employment Among Persons Living with HIV May 2000	Columbia
037	CHAIN Update Report #24: Comorbid Conditions: Intersecting Needs Among CHAIN Cohort May 2000	Columbia
038	CHAIN Update Report #23: Patterns of Adherence to Antiretroviral Medications 1995-1999 June 2000	Columbia
039	CHAIN Rapid Response Report #2: High Risk Behaviors: Unprotected Sex and Needle Sharing 1994-1999 Undated	Columbia
040	CHAIN Report: The Impact of Ancillary Services on Entry and Retention to HIV Medical Care in NYC: A Report to HRSA October 1999, Revised January 2000	Columbia
041	CHAIN Briefing Papers for Year 8 CHAIN Reports May 1999 [#s 18, 19, 20, 21, 22]	Columbia
042	CHAIN Update Report #22: Needs Assessment for Work-Related Services Among Persons Living with HIV/AIDS May 1999	Columbia

Table 2 *continued**Sources by Abstract
Code Number*

Table 2 *continued**Sources by Abstract
Code Number*

Code #	Title Date	Source/ Authors
A	B	C
043	CHAIN Update Report #21: Trends in Health Status May 1999	Columbia
044	CHAIN Update Report #20: Patterns of Adherence to Antiretroviral Medications May 1999	Columbia
045	CHAIN Update Report #19: Trends in Current Use of HIV Antiretroviral Therapy May 1999	Columbia
046	CHAIN Update Report #18: Using CHAIN Data to Measure Program Outcomes May 2000	Columbia
047	CHAIN Briefing Paper #1: The Unconnected Revisited May 1999	Columbia
048	CHAIN Update Report #16: Top Client-Identified Unmet Needs for Medical and Social Services May 1998	Columbia
049	Ryan White Title I Technical Assistance Services Impact Study and Needs Assessment, preliminary data Personal communication, 2002	Center for Health Policy Studies
050	CHAIN Update Report #15: Trends in Managed Care Plans and People Living with HIV April 1998	Columbia
051	PWA/HIV Advisory Group Strategic Plan Input December 2001	MO/APC
052	NYC Ryan White CARE Act Title I Consumer Advisory Groups Funding Recommendations Report March 2001	PWA/HIV Advisory Group
053	Winter 2001 Community Forums Executive Summary	MO/APC
054	Community Forum Report (Spring 2000) November 2000	MO/APC

Code #	Title Date	Source/ Authors
A	B	C
055	High Needs Index for Ryan White Title I Services April 1998	MO/APC
056	Draft High Needs Index II December 2001	MO/APC
057	New York City HIV Prevention Plan Prevention Planning Group Plan for HIV Prevention Services, 5 volumes 2000	DOH
058	2002 HIV Prevention Projects Cooperative Agreement Application September 2001	DOH
059	Workgroup Charge for Year 13 (March 2002-February 2003) Priority Setting November 2001	MO/APC
060	AOD Work Group Year 11 Priorities: Harm Reduction, Recovery Readiness, and Relapse Prevention: Escort and Follow-up Services June 2000	MO/APC AOD
061	Health Services Work Group Year 11 Priorities: Adult Day Care July 2001	MO/APC HSWG
062	Health Services Work Group Year 11 Priorities: Oral Health Care July 2001	MO/APC HSWG
063	Health Services Work Group Year 12 Priorities: Ambulatory Outpatient Care/Counseling and Testing July 2001	MO/APC HSWG
064	Health Services and AOD Work Groups Year 12 Priorities: Outpatient Medical Care/ Harm Reduction Clinic July 2001	MO/APC HSWG/AOD

Table 2 *continued**Sources by Abstract
Code Number*

Table 2 *continued**Sources by Abstract
Code Number*

Code #	Title Date	Source/ Authors
A	B	C
065	Housing Work Group Year 12 Priorities: Housing for PWAs in Need of Mental Health and Harm Reduction Services July 2001	MO/APC Housing WG
066	Housing Work Group Year 12 Priorities: Emergency Rental Assistance (CBC) July 2001	MO/APC Housing WG
067	Housing Work Group Year 12 Priorities: Emergency Rental Assistance (non HASA eligible) July 2001	MO/APC Housing WG
068	Housing Work Group Year 12 Priorities: Housing Enhancements for Special Populations July 2001	MO/APC Housing WG
069	Infrastructure and Housing Work Groups Year 12 Priorities: Technical Assistance for HIV/AIDS Housing Providers July 2001	MO/APC Infra and Housing WGs
070	Infrastructure Work Group Year 12 Priorities: Building and Sustaining Organizational Capacity June 2000	MO/APC Infra WG
071	Infrastructure Work Group Year 12 Priorities: Enhancing Capacity to Serve People Living with HIV/AIDS June 2000	MO/APC Infra WG
072	Infrastructure Work Group Year 12 Priorities: NYC and NYS PWA/HIV Leadership Training Institute June 2000	MO/APC Infra WG
073	Mental Health Work Group Year 12 Priorities: HIV/AIDS Mental Health Services in Primary Care Settings July 2001	MO/APC MHWG

Code #	Title Date	Source/ Authors
A	B	C
074	Social Services Work Group Year 11 Priorities: Transportation July 2001	MO/APC SSWG
075	Social Services Work Group Year 11 Priorities: Client Advocacy July 2001	MO/APC SSWG
076	Social Services Work Group Year 11 Priorities: Food and Nutrition July 2001	MO/APC SSWG
077	Social Services Work Group Year 11 Priorities: Custody Planning and Transitional Supports June 2000	MO/APC SSWG
078	Social Services Work Group Year 12 Priorities: Promoting Access to Early Intervention Services for Title I Program Funding (CBC) July 2001	MO/APC SSWG
079	Work Group Priorities for Years 7, 8, 9, and 10	MO/APC
080	Ryan White Title I Program Monitoring Report to the NYCDOH, (March 2000-February 2001) January 2002	MHRA
081	Title I Year 11 Contracts	MHRA
082	P & E Committee Initiatives Status Report Undated	MO/APC
083	CBC Outcome Evaluation Quarterly Reports (May-August 2001) September 2001	MO/APC NYAM
084	Housing Needs Assessment Chart of Milestone, Deliverables, and Timeframes 2001	MO/APC
085	AOD Quantitative Study February 2002	NYAM

Table 2 *continued*
*Sources by Abstract
Code Number*

Table 2 *continued**Sources by Abstract
Code Number*

Code #	Title Date	Source/ Authors
A	B	C
086	Assessing the Effects of Selected Policy and Legislation February 2002	MO/APC McClain
087	DRAFT Policy on Early Intervention Services/Maintaining Appropriate Referral Relationships December 2001	MO/APC
088	Report on the Mental Health Tool Feasibility Study Undated	MO/APC Cicatelli
089	Needs Assessment and Service Utilization Study of Dental Care for HIV Infected Persons December 2001	MO/APC Montefiore
090	Draft Qualitative Needs Assessment of HIV Services Among Dominican, Mexican, and Central American Immigrant Populations Living in the New York EMA December 2001	MO/APC Sociomedical Resource Associates
091	Senior Needs Assessment Project: The Housing and Service Needs of Older New Yorkers Infected [With] and Affected by HIV/AIDS May 1999	MO/APC Columbia
092	Towards a Comprehensive Plan for Syringe Exchange in New York City 1999	NYAM
093	Fair Work Policies for People Living with HIV/AIDS October 1998	MTS
094	Evaluation Studies at Selected CARE Act Pilot Sites February 1999	Columbia
095	Health Care Accessibility Among People that Inject Drugs or Use Crack Cocaine March 2000	NYAM

Code #	Title Date	Source/ Authors
A	B	C
096	2002 Tri-County Title I Steering Committee Meeting Scheduled	Westchester DOH
097	2002 Planning Council Calendar	MO/APC
098	2002 PC Executive Committee Calendar	MO/APC
099	2002 P & E Committee Calendar	MO/APC
100	2002 Work Groups Calendar	MO/APC
101	Roster of PC Members & Chairs	MO/APC
102	Roster of Work Group Coordinators	MO/APC
103	New York Strategic Plan for HIV/AIDS Services 1998-2001	MO/APC
104	Consolidated Planning Tool 1997	MO/APC
105	Unmet Needs Consultation Report November 2000	HRSA
106	Needs Assessment and Comprehensive Planning Summer 2001	HRSA
107	Title I Request for Proposals May 2000	MHRA
108	Title I Request for Proposals January 2002	MHRA
109	CHAIN Update Report #41: Housing Status and Health Outcomes among Persons Living with HIV/AIDS November 2001	Columbia
110	Prison Planning Group: Recommendations and Priorities Report April 9, 2001	Prison Planning Group
111	Results of the PWA/HIV Advisory Group Survey: Recommendations for Year 12 Priorities July 2001	MO/APC

Table 2 *continued*
Sources by Abstract
Code Number

Table 2 *continued**Sources by Abstract
Code Number*

Code #	Title Date	Source/ Authors
A	B	C
112	Preliminary Report: Regional Gap Analysis (Tri-County: Lower Hudson HIV CARE Network) March 2001	Westchester DOH
113	Notice of AIDS Funding Availability: Direct Services and Technical support for HIV/AIDS Organizations January 2002	Westchester DOH
114	Estimating the range of HIV+ individuals who know their status but are not engaged in care Personal Communication from D. Abramson January 2002	Columbia
115	Measuring Unmet Need for HIV Care December 2001	UCSF
116	Unemployment Rate Rises Again in Wake of Attacks January 18, 2002	New York Times
117	Title I and Title II Regional Training Conference July 2001	HRSA
118	Community Need Index (Hudson Valley Region) 2000	Westchester DOH
119	Tri-County Title I FY 2002 Grant Application Tables October 2001	Westchester DOH
120	Year 10 RWCA Title I Tri-County Service Utilization Data March 2000-February 2001 DATE?	Westchester DOH
121	Race and HIV Infection in New York City Men Who Have Sex With Men 2001	NYCDOH, The New York Blood Center, and the Centers for Disease Control and Prevention

Code #	Title Date	Source/ Authors
A	B	C
122	Estimates of People Living with AIDS in New York City, 1999 Edition March 2000	NYCDOH
123	Mother-to-Child HIV Transmission Reduced 'Dramatically' in New York Since 1997 Newborn HIV Testing Law, February 12, 2002	AP/Albany Times Union
124	Title I HIV Quality of Care Program February 2002	Agins et al NYSDOH
125	AIDS in New York City: A Profile of the Epidemic February 2002	MO/APC
126	Congregate and Scattered Site HIV/AIDS Housing Data August 2001	NYC HIV/AIDS Services Administration
127	Implementation of Named Surveillance for Human Immunodeficiency Virus (HIV) Infection for New York City: Preliminary Data on the First 18 Months of HIV Reporting 2001	NYCDOH D. Nash, L. Jones, J. Sackoff, T. , et al., DOH
128	Sexual Health Survey: Sexual Health Practices of Gay, Bisexual, and Homosexually Active Men in New York City, June 1999	T. Mayne, et al., Gay Men's Health Crisis
129	New York City Department of Health Presents 2001 Data on Syphilis (Press Release) March 6, 2002	NYCDOH

Table 2 *continued*
Sources by Abstract
Code Number

Epidemiologic Profile

A. Introduction

This section of the needs assessment presents an epidemiological profile of HIV/AIDS in New York City, highlighting how the demographics of the disease have changed over the past decade, the epidemiology of the disease as it currently exists, and emerging trends that will likely shape the epidemic over the coming years.

B. Methods

The epidemiological data presented in this section were obtained from the New York City Department of Health (DOH), HIV/AIDS Surveillance Program, and a number of other sources listed on the master roster.³

In some cases tables or charts included were taken directly from documents on this list. In other cases material from multiple documents was combined to create a new table or chart.

C. General Epidemiological Findings

As of December 31, 2000, a total of 120,783 cumulative adult and adolescent AIDS cases had been diagnosed in New York City. Of these, 43,150 people were known to be living with the disease at the end of 1999, the most recent year in which these data were publicly available.

The largest proportion of AIDS cases result from injection drug use – 45% of cumulative cases and 41% of living cases. The disease disproportionately affects:

- Males – 77% of cumulative cases and 74% of living cases.
- People of color⁴ – 73% of cumulative cases and 76% of living cases.
- Manhattan residents – 38% of cumulative cases and 35% of living cases.

³ Unless otherwise noted, data in Section 3 are derived from documents 002, 122, 123, 124, and 125.

⁴ All subsequent uses of the term “people of color” refer to the following groups: African Americans, Blacks, Latinos, Hispanics, Native Americans, Asian Americans, Native Hawaiians, and Pacific Islanders.

Potentially critical changes in disease demographics have been observed in the last several years:

- The proportion of AIDS cases diagnosed among women in a given year has increased from 23% in 1992 to 31% in 2000.
- The proportion of AIDS cases diagnosed among people of color in a given year has increased from 74% in 1992 to 83% in 2000.
- The proportion of AIDS cases diagnosed in a given year resulting from heterosexual contact has increased from 10% in 1992 to 17% in 2000.
- Beginning in the late 1990s, the majority of new AIDS cases were diagnosed in those over 39 years of age.

Just published New York State Department of Health data reveal that the number of syphilis cases in New York City doubled from 2000 to 2001, with most of the increase coming from men who have sex with men. According to preliminary data presented at the National STD Prevention Conference in March 2002, 282 New York City cases of primary or secondary syphilis were recorded in 2001, compared to 117 in 2000, continuing a trend that began in 1999. The rise in cases among MSMs may be particularly troubling because it indicates a rise in unprotected sex. Syphilis facilitates HIV transmission during the primary and secondary stages when sores are open on the skin (document 129).

As of December 31, 2000, 1,975 cumulative pediatric AIDS cases had been diagnosed in New York City. Of these, over 700 children were still known to be living with the disease at the end of 1999, the most recent year in which these data were publicly available. The vast majority of these are children of color – 93% of both cumulative and living cases – who were infected from mothers who use injection drugs – 47% of cumulative cases and 44% of living cases.

Starting in the mid-1990s, the introduction of new drug therapies resulted in a sharp decline in the number of adult and pediatric deaths reported annually and a concomitant increase in the number of people living with HIV/AIDS. In 1993 the number of adult/adolescent AIDS deaths per year peaked at 8,349. By 1999 that number had declined to 729, a 91% reduction.

Simultaneously, advancements in pre- and post-natal HIV treatment have led to a major reduction in pediatric HIV/AIDS cases. According to a recent Associated Press/Albany Times Union article, the rate of vertical HIV transmission from mother to child in New York State has decreased "dramatically" -- from 25% to 3.5% -- since the implementation of a 1997 law requiring infant HIV testing and maternal notification. In fact, during 1999, only 13 new AIDS cases among children were reported.

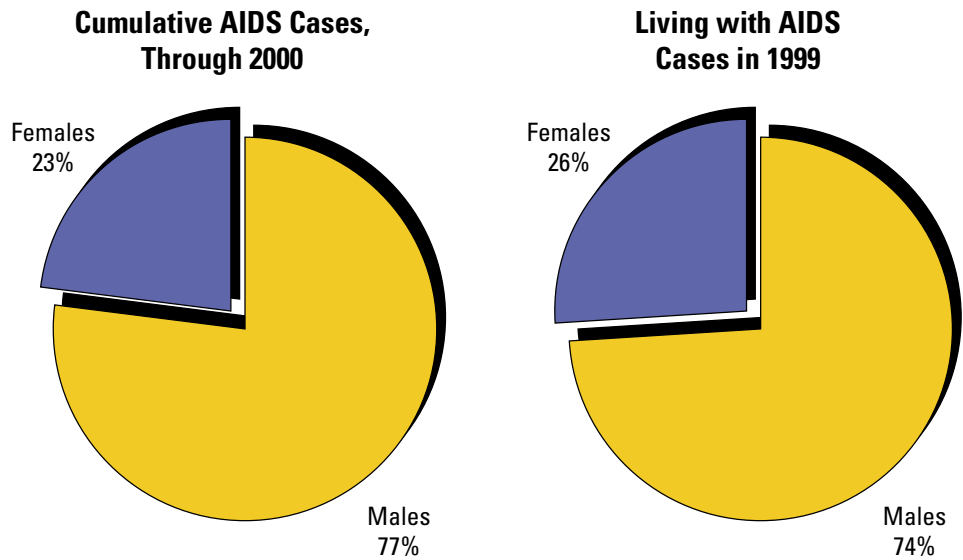
At the national level, an estimated one-third of persons with HIV know their status and are not in care. This group is the focus of considerable attention because of the potential to bring them into HIV care. At the present time, estimates of the population of persons in New York City who know their status and are not in care are considerably lower. One recent estimate produced a range of 2,250 to 7,200 individuals in New York City who know their HIV-positive status but are unconnected from primary medical care either chronically or episodically.⁵

Figures 1-8, below, are charts, graphs, and maps illustrating these findings. More detailed information, in the form of AIDS prevalence counts by zip code, are included in Appendix A.

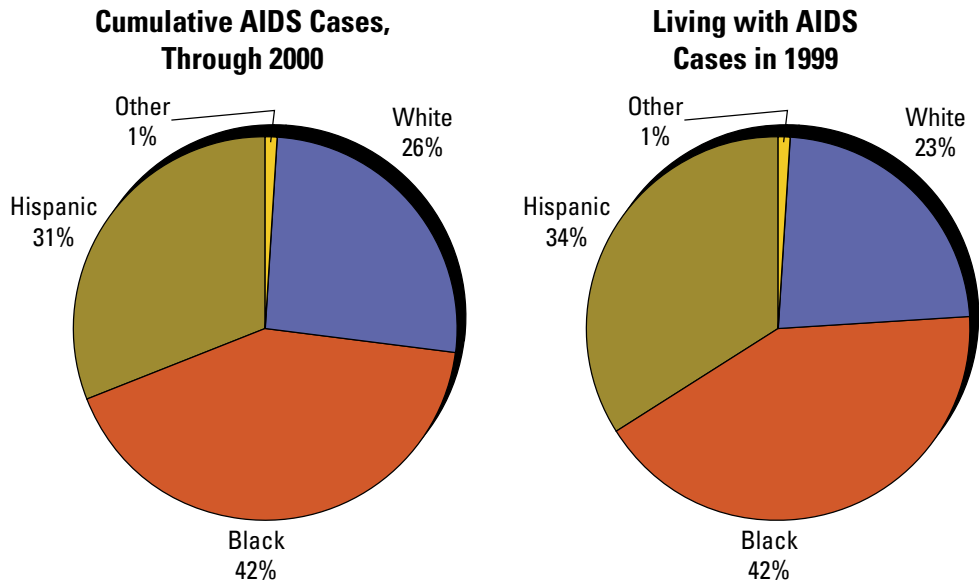
⁵ The estimate was developed in early 2002 by the CHAIN project at Columbia University. The rationale is that (1) there are 48,000 unduplicated persons who have filed an HIV-related Medicaid claim in 1999/2000, (2) the payor mix on all HIV-related hospital discharges in 1999 was 2/3 Medicaid and 1/3 all others, (3) CHAIN estimated in 1995 that 6.5% of HIV+ persons [in care] (sic) were unconnected to care, and (4) CHAIN #35 found that 3.5% of the cohort between 1997-2000 indicated at any given time they did not have a primary medical provider, meaning they are episodically or disconnected from medical care. The assumptions leading to the estimate are that (1) the total number of individuals in care is 72,000 (48,000 Medicaid beneficiaries plus 24,000 non-Medicaid beneficiaries) and assumes that the distribution of people in care is equivalent to the distribution of people who have been hospitalized; (2) the lowest number estimated to be unconnected would be $72,000 \times 3.5\%$, or 2,520; (3) the middle number estimated to be unconnected would be $72,000 \times 6.5\%$, or 4,680; and (4) the higher end of the estimate would be a combination of those episodically in and out of care (2,520) and those more chronically disengaged from care (4,680), or 7,200.

Figure 1. Adult/adolescent AIDS cases in New York City, cumulative (2000) and living (1999) by gender, race, borough, and mode of transmission (men and women)

By Gender

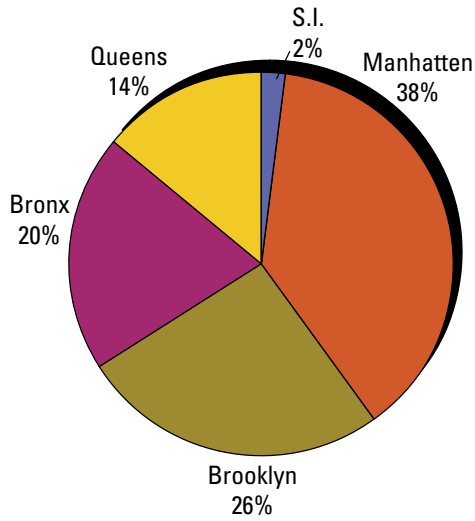


By Race/Ethnicity

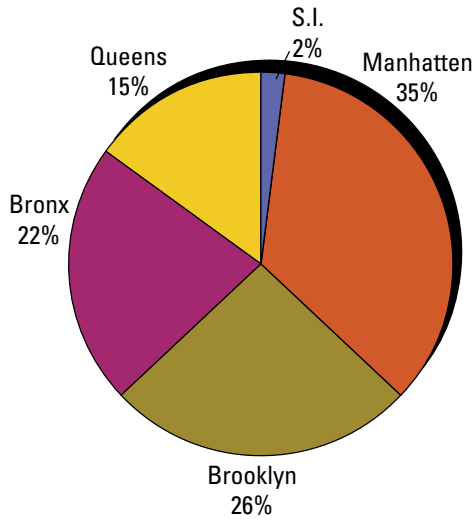


By Borough

Cumulative AIDS Cases, Through 2000

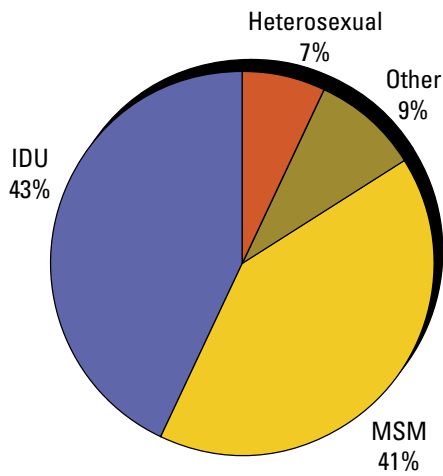


Living with AIDS Cases in 1999

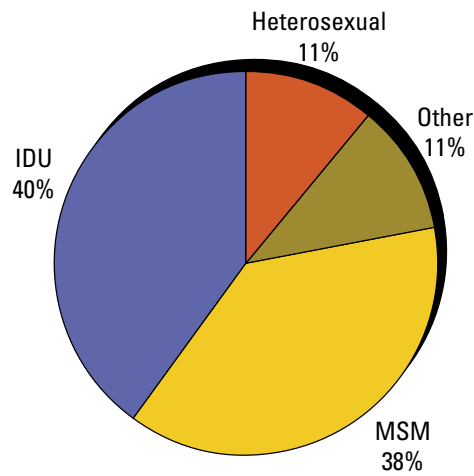


By Mode of Transmission for Men

Cumulative AIDS Cases, Through 2000



Living with AIDS Cases in 1999



Mode of Transmission for Women

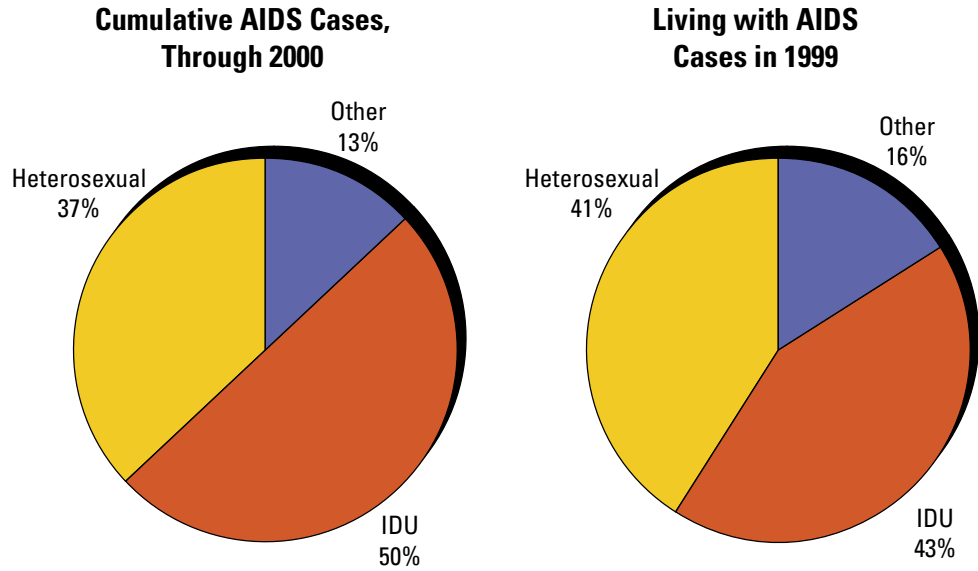
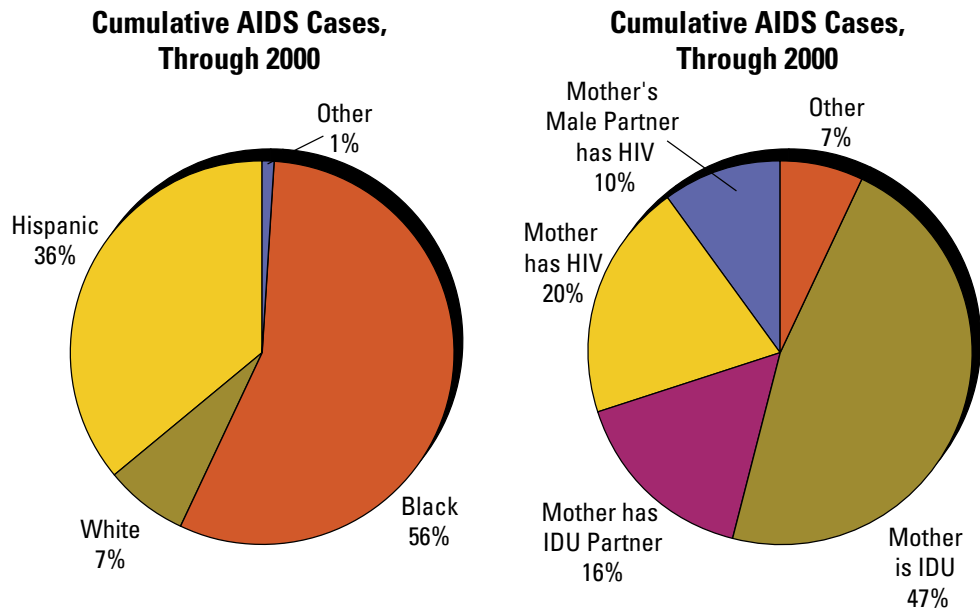


Figure 2. Cumulative pediatric² AIDS cases in New York City



² Children less than 13 years old at time of diagnosis. Categories defined by CDC.

Figure 3. Adult AIDS Cases by Year of Diagnosis

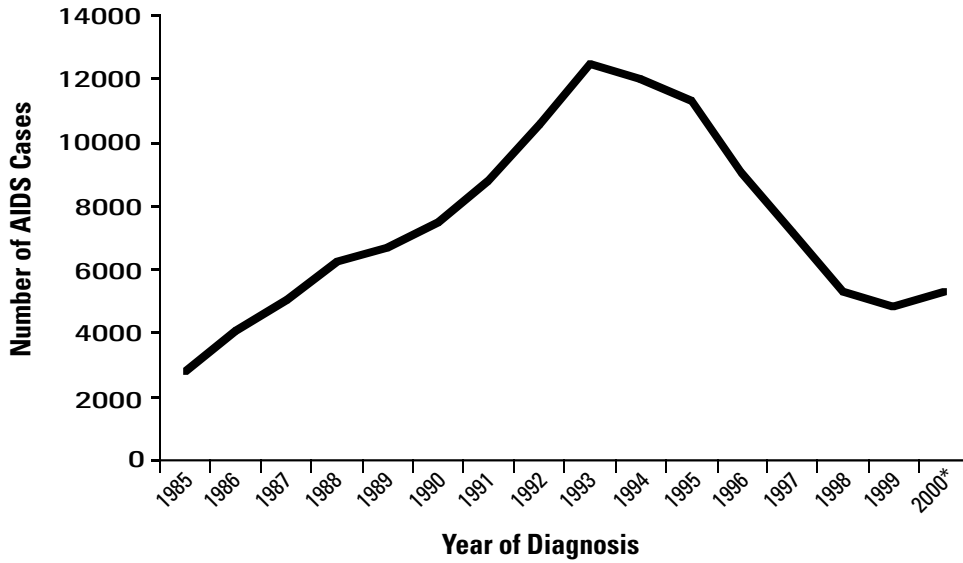
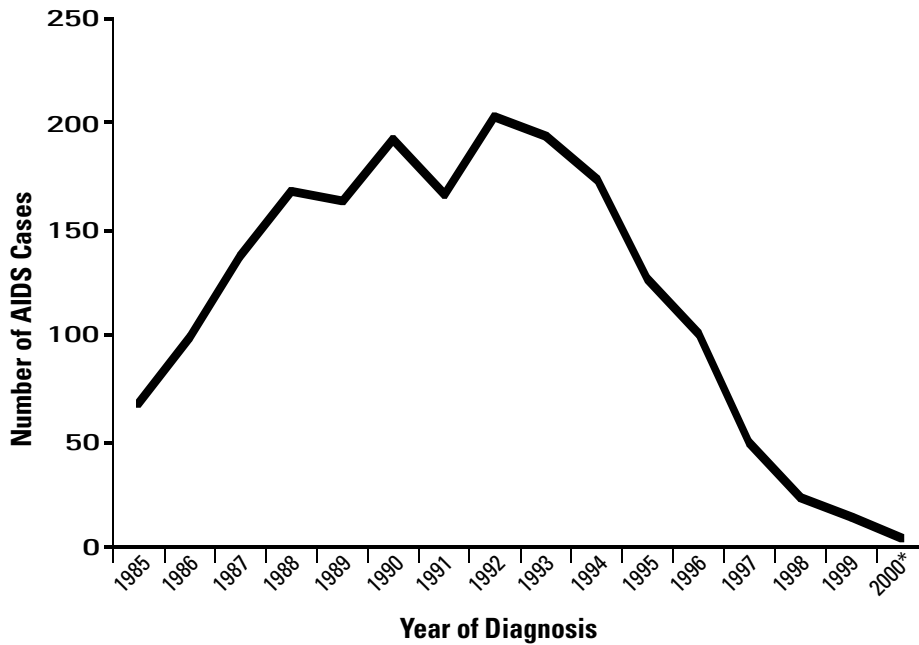


Figure 4. Pediatric AIDS Cases by Year of Diagnosis



* Data are incomplete due to reporting lag.

Figure 5. Adult AIDS Cases by Gender and Year of Diagnosis

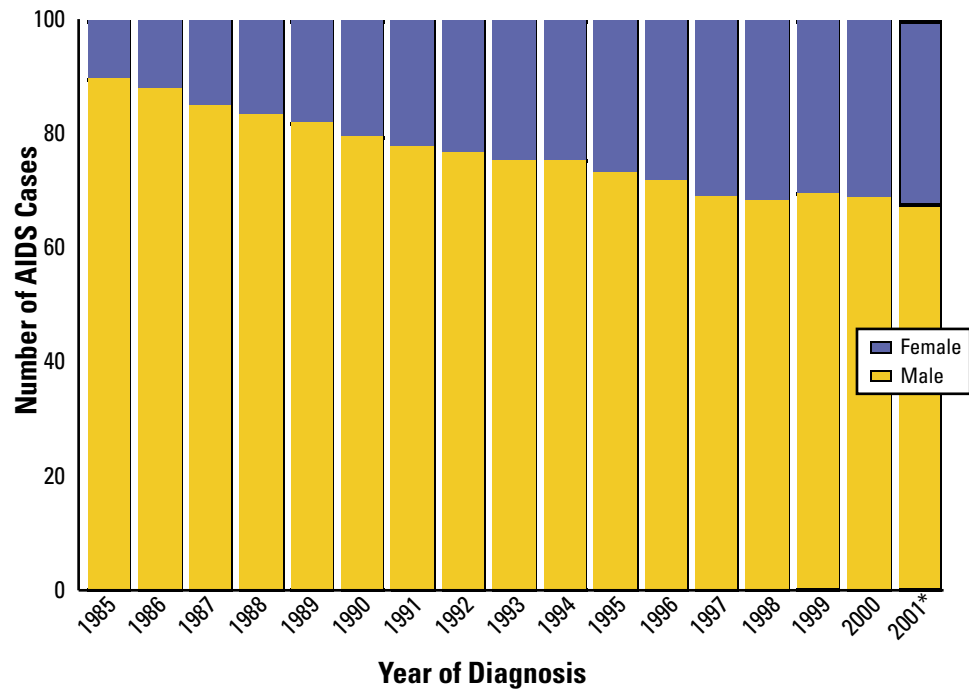
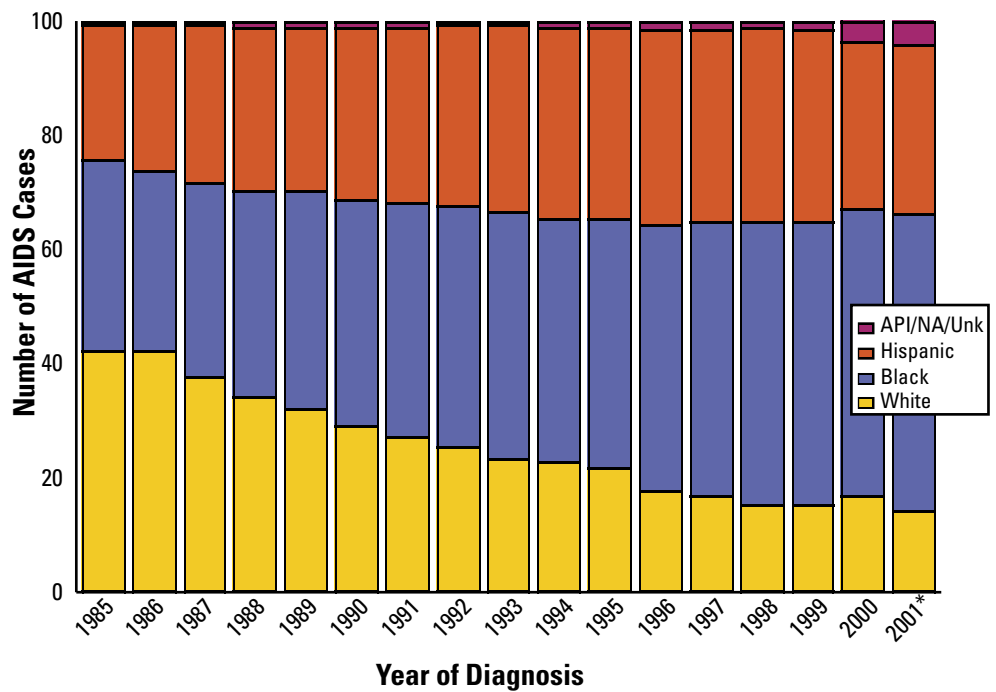
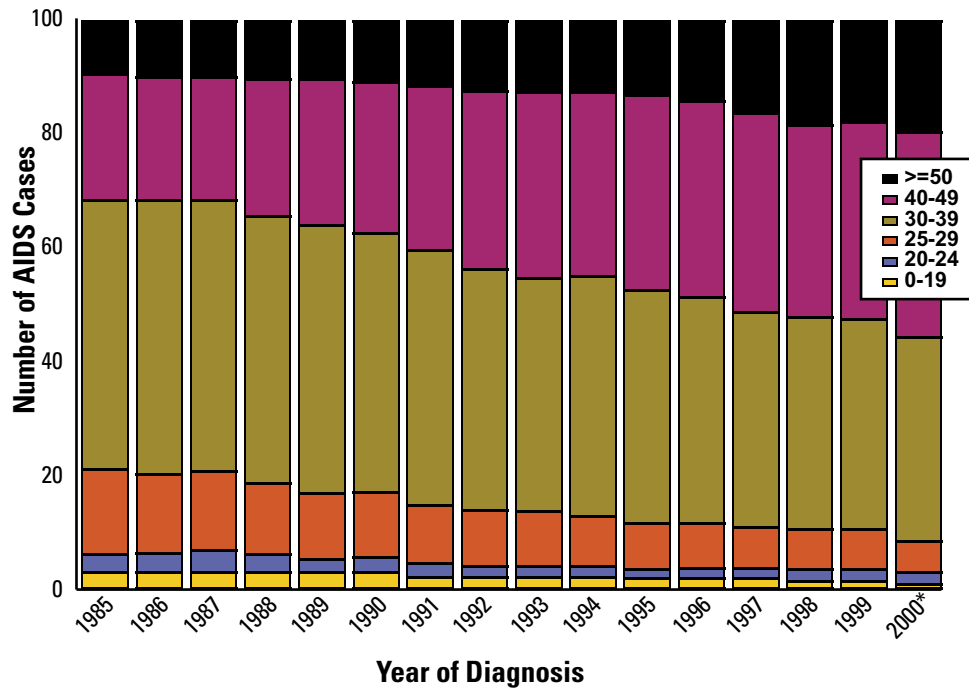


Figure 6. Adult AIDS Cases by Race/Ethnicity and Year of Diagnosis



* Data are incomplete due to reporting lag.

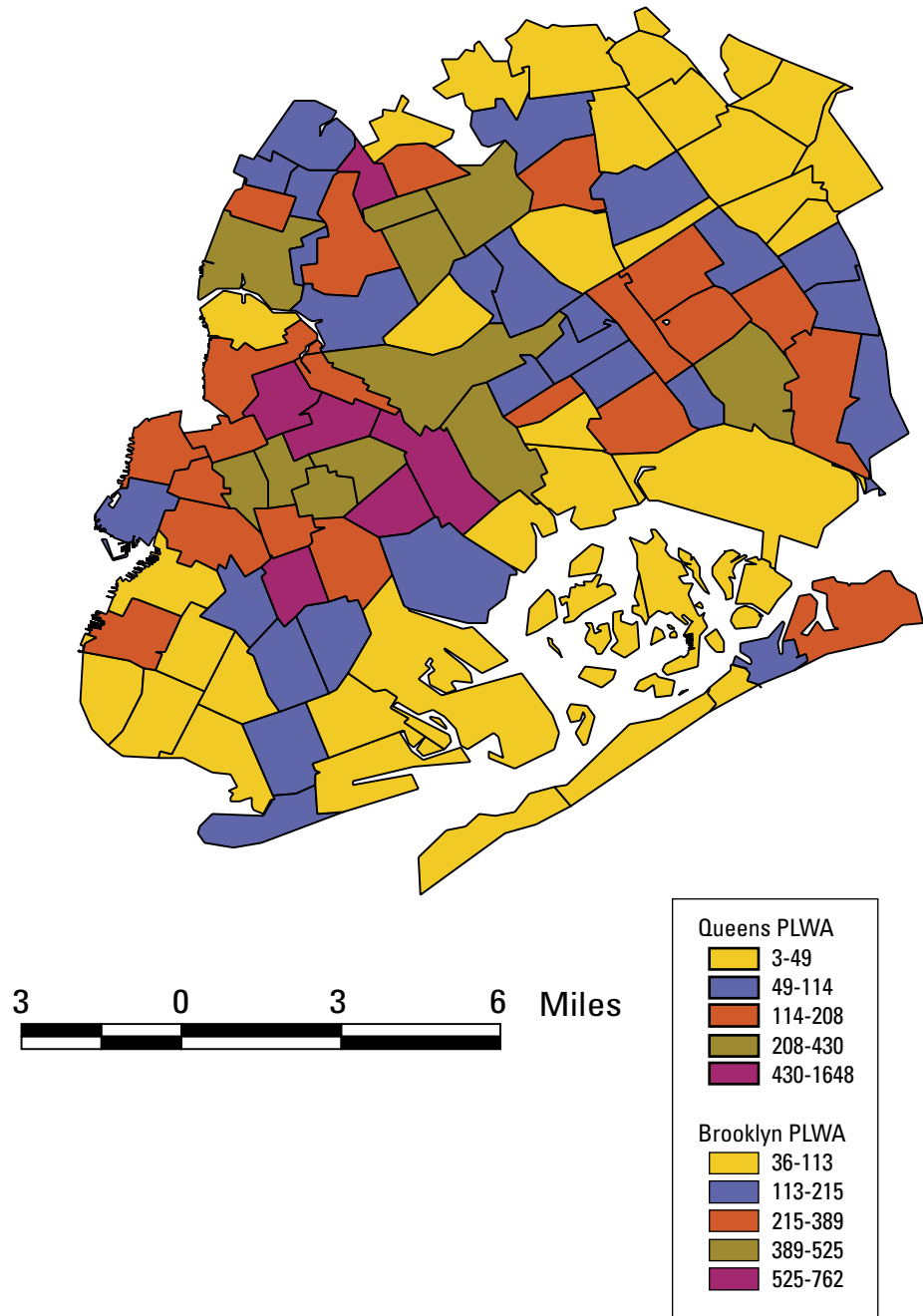
Figure 7. Adult AIDS Cases by Age Group and Year of Diagnosis



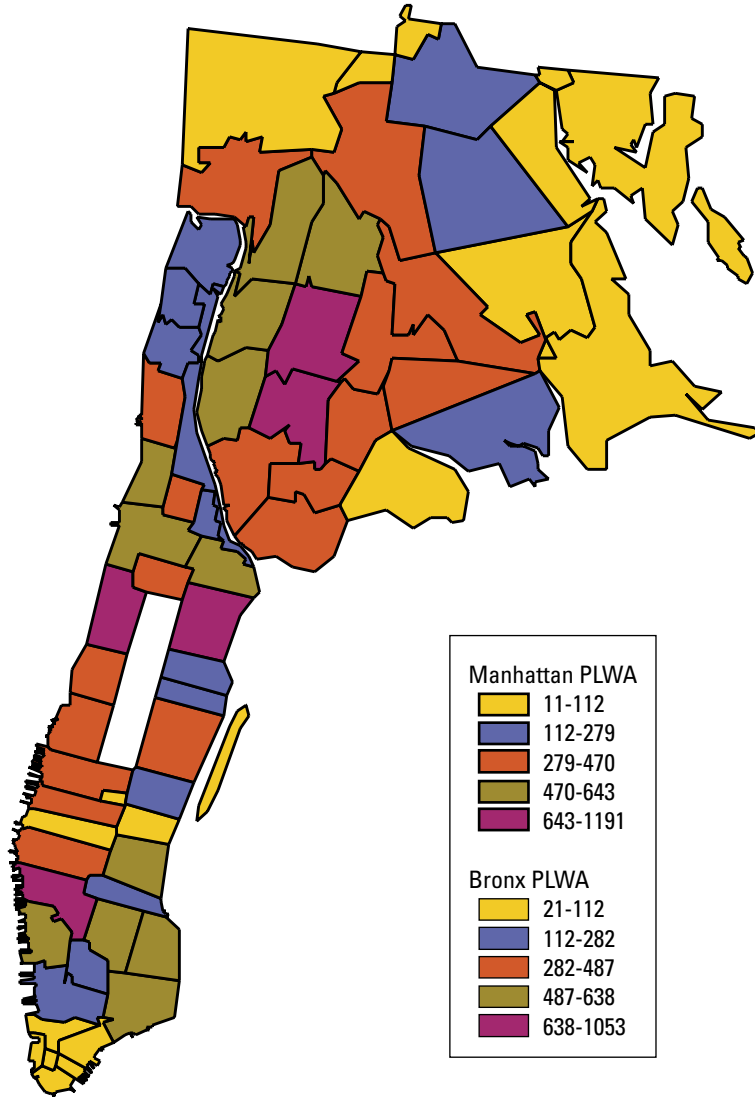
* Data are incomplete due to reporting lag.

Figure 8. PLWA 2000: Queens and Brooklyn, Manhattan and Bronx, Staten Island

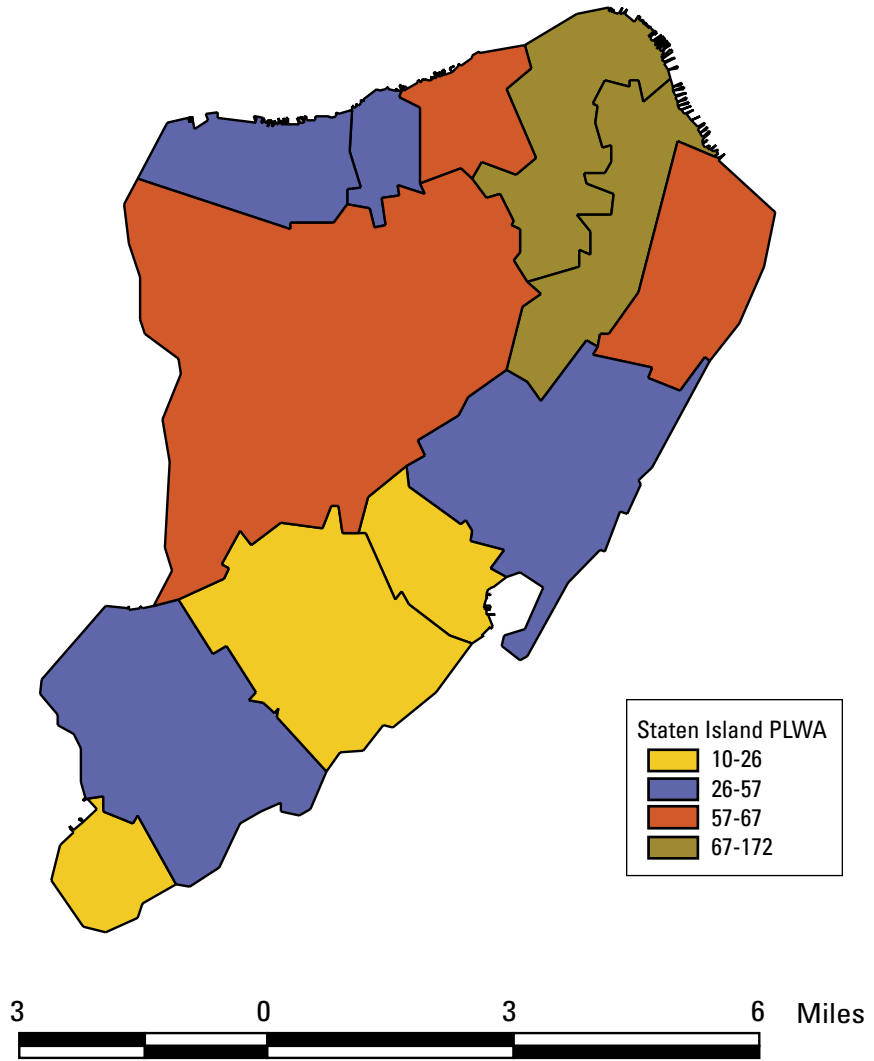
Queens and Brooklyn



Manhattan and Bronx



Staten Island



D. Sociodemographics

Table 3 presents non-HIV specific New York City demographic data by borough, and by gender and race/ethnicity. It also compares population changes between 1990 and 2000. During this period the total population of New York City grew by 9.4%, while the Hispanic population grew by 21.1% (to 2,160,554), the Asian/Pacific Islander population grew by 59.9% (to 783,058), the black population grew by 8.5% (to 1,962,154), while the white population fell by 11.4% (to 2,801,276).

Between 1990 and 2000, Manhattan grew the least (with a 3.3% growth rate) and Staten Island the most (with a 17.1% growth rate). In 2000, Brooklyn was the largest borough (with 30.8% of the total New York City population), followed by Queens (27.8%), Manhattan (19.2%), the Bronx (16.6%) and Staten Island (5.5%).

Race/ethnicity changes at the borough level generally mirrored those of the city as a whole. The white population declined in all boroughs, except Staten Island, with the greatest declines in the Bronx and Queens. The Hispanic population grew in all boroughs, with the greatest increase in the Bronx, Queens, and Staten Island. The black population grew at roughly equal rates across boroughs, with the exception of Staten Island, which experienced a large percentage growth in this population and Manhattan, which experienced a decrease.

Table 3. Race/Borough Populations and Sub-populations in 2000 Compared to 1990

Category	Number	Percent	Percent Change Since 1990
A	B	C	D
New York City	8,008,278	100.0	9.4
Gender			
Male	3,794,204	47.4	10.4
Female	4,214,074	52.6	8.5
Race/Ethnicity			
White	2,801,267	35.0	-11.4
Black	1,962,154	24.5	6.2
Hispanic	2,160,554	27.0	21.1
Asian/ Pacific Islander	783,058	9.8	59.9
Other	301,245	3.8	N/A
Brooklyn	2,465,326	100.0	7.4
	(30.8% of total NYC population)		
Gender			
Male	1,156,446	46.9	8.0
Female	1,308,880	53.1	6.4
Race/Ethnicity			
White	854,532	34.7	-7.4
Black	848,583	34.4	6.4
Hispanic	487,878	19.8	5.5
Asian/ Pacific Islander	185,094	7.5	74.6
Other	88,751	3.6	N/A
Bronx	1,332,650	100.0	10.7
	(16.6% of total NYC population)		
Gender			
Male	620,171	46.5	11.7
Female	712,479	53.5	9.8
Race/Ethnicity			
White	193,651	14.5	-28.9
Black	416,338	31.2	12.8
Hispanic	644,705	48.4	23.2
Asian/ Pacific Islander	39,032	2.9	25.1
Other	38,924	2.9	N/A

Category	Number	Percent	Percent Change Since 1990
A	B	C	D
Manhattan	1,537,195	100.0 (19.2% of total NY population)	3.3
Gender			
Male	729,534	47.5	4.1
Female	807,661	52.5	2.6
Race/Ethnicity			
White	703,873	45.8	-3.1
Black	234,698	15.3	-10.1
Hispanic	417,816	27.2	8.1
Asian/ Pacific Islander	143,863	9.4	35.3
Other	35,355	2.3	N/A
Queens	2,229,379	100.0 (27.8% of total NY population)	14.2
Gender			
Male	1,073,568	48.2	15.7
Female	1,155,811	51.8	12.0
Race/Ethnicity			
White	732,895	32.9	-21.8
Black	422,831	19.0	8.2
Hispanic	556,605	25.0	46.0
Asian/ Pacific Islander	390,164	17.5	69.8
Other	124,845	5.6	N/A
Staten Island	443,728	100.0 (5.5% of total NYC population)	17.1
Gender			
Male	214,485	48.3	17.1
Female	229,243	51.7	17.1
Race/Ethnicity			
White	316,316	71.3	4.4
Black	39,704	8.9	40.9
Hispanic	53,550	12.1	77.1
Asian/ Pacific Islander	24,905	5.6	51.1
Other	9,318	2.1	N/A

Table 3 *continued*

*Race/Borough
Populations and
Sub-populations
in 2000 Compared
to 1990*

Because of rounding, not all columns add to 100%

N/A=compatible category did not exist in 1999

Source: 2000 US Census Data

Table 4 presents the race and borough distribution of AIDS prevalence in New York City and the percentage of new Title I clients by service-related work group areas in 2000 (also known as Year 10).

This table shows that the epidemic has disproportionately impacted the black and Hispanic communities. It also shows that new Title I client service use has generally followed suit, with 51.6% of all new clients being black and 39.1% being Hispanic – a trend that generally holds across work group areas.

The table also shows that one-third of all new Title I clients are from the Bronx although the Bronx has 20% of the city's AIDS cases, likely reflecting the greater needs of individuals residing in this borough. Roughly one-quarter of new Title I clients come from Brooklyn (with 26% of the total city cases) and one-quarter from Manhattan (with 38% of the total city cases).

Table 4. Race/Borough Distribution of AIDS Prevalence and New Clients by Work Group Area

Race/ethnicity and borough	Percentage of total New York City Population	Percentage of total New York City AIDS prevalence	Percentage of new Title I clients in Year 10 (3/2000-2/2001) by service-related Work Group area							Proportion of active enrollees in ADAP pools in Year 2000
			Total	Health	Housing	Mental Health	Social Services	Alcohol & other drugs		
A	B	C	D	E	F	G	H	I	J	
Black	24.5	42.0	51.6	54.0	57.8	46.4	49.7	55.1	38.6	
Hispanic	27.0	31.0	39.1	37.4	34.4	41.8	40.6	36.4	34.4	
White	35.0	26.0	8.5	7.5	7.5	10.4	8.8	7.8	21.5	
Other	13.6	1.0	0.9	1.1	0.3	1.4	0.9	0.6	1.7	
Bronx	16.6	20.0	33.2	25.1	35.0	29.5	37.0	32.5	20.1	
Brooklyn	30.8	26.0	25.9	31.2	25.7	20.3	29.0	15.5	25.5	
Manhattan	19.2	38.0	24.0	29.3	30.1	34.4	19.4	25.6	33.7	
Queens	27.8	14.0	14.4	12.2	8.4	15.5	11.0	25.0	18.6	
Staten Island	5.5	2.0	2.6	2.4	0.9	0.3	3.7	1.3	2.1	

Because of incomplete data, not all columns add to 100%
 Figures in Columns D through I are not unduplicated
 Sources: US Census data for column B, NYCDOH for column C, MHRA PMR 3/2000-2/2001 (document 080) for columns D through I, NYSDOH for column J.

E. Assessment of Populations with Special Needs

Table 5 presents specific epidemiological data and HIV infection risk trends among the following special populations:

- Infants and children (under 13 years old)
- Youth (13-24 years old)
- Injecting Drug Users (IDUs)
- Men of color who have sex with men
- White (Anglo) men who have sex with men
- Women of child-bearing years (13 years and older)
- Other substance users
- Mentally ill chemical abusers
- Immigrants and Undocumented persons
- Homeless population in shelters, SROs, and "on the street"
- Detained inmates and recently released inmates

Table 5. Assessment of Populations with Special Needs**Infants and Children (under 13 years old)***1. Estimated number of persons in this population (regardless of HIV status)*

1,632,809, children 14 and under

2. Estimated number of persons in this population living with AIDS

Over 700 children were still known to be living with the disease at the end of 1999 (the most recent year in which these data were available).

3. Estimated number of persons in this population with HIV infection (including AIDS)

Unknown

4. Estimated HIV prevalence rate for this population

Unknown

5. Description of the population, including geographic distribution in the EMA, income level, language barriers, and other characteristics

Of living pediatric AIDS cases in 1999, 61% were black, 7% white, and 32% Hispanic. 34% lived in Brooklyn, 28% in the Bronx, 17% in Manhattan, 13% in Queens, and 2% in Staten Island.

6. HIV infection and risk trends in this population

The vast majority of HIV-infected pediatric cases are children of color who were infected from mothers who use injection drugs (47% of cumulative cases; 44% of living cases). Other notable routes of infection, based on 1999 living cases, include: mother is sex partner of IDU (12%), mother is sex partner of man with HIV/AIDS (15%), mother with HIV/AIDS—risk not specified (24%).

The rate of vertical HIV transmission from mother to child in NY state has decreased from 25% to 3.5% since 1997. During 1999, only 13 new AIDS cases among children were reported.

Table 5 continued on next page

Table 5 *continued*

Assessment of
Populations with
Special Needs

Youth
(13-24 years old)

Youth (13-24 years old)

1. Estimated number of persons in this population (regardless of HIV status)

1,496,343

2. Estimated number of persons in this population living with AIDS

1,605

3. Estimated number of persons in this population with HIV infection (including AIDS)

Unknown

4. Estimated HIV prevalence rate for this population

Unknown

5. Description of the population, including geographic distribution in the EMA, income level, language barriers, and other characteristics

Youth comprise approximately 16% of the overall population, and are uniformly distributed geographically within the EMA; among households headed by persons <25, 40% have incomes \$14,999 or below; among all persons 12-17, 39% fall below the federal poverty level; among persons 5-17, 6% speak English “not well” or “not at all”; among persons 14-17, 8% are “linguistically isolated” at home.

6. HIV infection and risk trends in this population

While the proportion of new or live AIDS cases among youth is small, as most individuals infected at a young age do not progress to AIDS until their twenties or thirties, the converse is also true – in 2000, of those living with AIDS in NYC who were diagnosed in their twenties (13%) or thirties (42%), many were likely infected while adolescents. In NYC in 2000:

- Among persons living with AIDS, 306 (0.65%) were diagnosed as adolescents (54% are black, 38% are Hispanic, 6% are white, and 1% are another race – 50% are males, 50% are females);
- Among cumulative AIDS cases, 480 (0.4%) were diagnosed as adolescents;
- Among AIDS cases diagnosed in 2000, 31 (1.4%) are adolescents (35% male, 65% female)

Risk for HIV infection is especially high among young men who have sex with men (YMSM). Among 3,492 YMSM ages 15-22 surveyed between 1994-1998 in seven cities (541 in NYC), HIV seroprevalence was highest in NYC (12.1% compared to 7.2% overall), and was higher among blacks (18.4%), Latinos (8.8%), and men of mixed race (16.7%), than among whites (3.1%). A high prevalence (41% overall) of unprotected anal sex during the preceding six months was also noted among these young

men; 67% reported having had a female sexual partner at some point in their lives, while 23% reported having had a female sexual partner in the past six months.

In NYC, annual HIV incidence among YMSM in this cohort was 7.6% (compared to 2.6% overall). Among all seven cities, HIV incidence was highest among blacks (4.0%) and persons of mixed race (5.4%), and was similar between homosexual and bisexual men. Recent risk behaviors associated with high HIV incidence were having greater than or equal to 5 male sex partners, having unprotected anal sex with men, or having injected drugs.

Serosurveys indicate sharply varying risks among youth in different subpopulations – for example, HIV seroprevalence was:

- 1.2% in 1999 among 16,129 NYDOH Public Health Laboratories samples submitted by persons <20 year old; 1.9% among 44,863 samples submitted by persons 20-29 years old;
- 1.4% in 1999 among 296 NYC STD Clinic patients <20 years; 1.2% among 994 patients 20-24;
- 2.4% in 1999 among 124 NYC chest clinic patients with TB <25 years;
- 0.1% in 1999 among 5,928 NYC military recruits <25 years;
- 0.4% in 1998 among 962 NYC jail entrants <20 years (0.3% of men, 1.1% of women); 1.8% among 1,439 NYC jail entrants 20-24 (1.1% of men, 6% of women);
- 0.18% in 2000 among 11,401 mothers (ages 10-19) giving birth in the EMA; 0.40% in 2000 among 29,089 mothers (ages 20-24) giving birth in the EMA;
- 0.3% in 1997 among 2,894 women <24 seeking abortions in NYC.

Table 5 *continued*

*Assessment of
Populations with
Special Needs*

*Youth
(13-24 years old)*

Table 5 continued on next page

Table 5 *continued*

Assessment of
Populations with
Special Needs

Injecting Drug Users
(IDUs)

Injecting Drug Users (IDUs)

1. *Estimated number of persons in this population (regardless of HIV status)*

+ 160,000

2. *Estimated number of persons in this population living with AIDS*

18,580 (includes MSM/IDU)

3. *Estimated number of persons in this population with HIV infection (including AIDS)*

59,670 (includes MSM/IDU)

4. *Estimated HIV prevalence rate for this population*

20-37% (20,000-37299:100,000)

5. *Description of the population, including geographic distribution in the EMA, income level, language barriers, and other characteristics*

Geographic rates of injection drug use (as indicated by opioid-related hospital discharges, heroin emergency room mentions, deaths involving heroin, heroin arrests, and drug treatment admissions) vary markedly and often closely parallel AIDS prevalence rates. For example, IDU rates (as measured by opioid-related discharges) are especially high (above the 80th percentile for NYC as a whole) in 56% of the Bronx, 14% of Brooklyn, 37% of Manhattan, and 8% of Queens zip codes.

Heroin admissions constitute 44% of drug treatment admissions in NYC, and are overwhelmingly male (73%), older than 35 (62%), more likely to be Hispanic (52%) than black (25%) or white (21%), usually readmissions to treatment (86%), are likely to report cocaine as a secondary drug of abuse (34%). Compared with injectors, those who snort heroin are more likely to be Hispanic (55% vs. 48%) and first admissions to treatment (16% vs. 11%). In contrast, injectors are more likely to be white (32% vs. 17%), to report cocaine as a secondary drug of abuse (40% vs. 30%), and to have started using before 20 (57% vs. 41%).

6. HIV infection and risk trends in this population

Substance abuse is widespread in the New York EMA and injection use in particular continues to be a dominant factor in the New York HIV epidemic. Seventy percent of reported AIDS cases in NYC are directly or indirectly related to injecting drug use (i.e., women infected through heterosexual contact with an IDU or children born to HIV-infected women). In NYC:

- Among persons living with AIDS in 2000, 37% are associated with IDU;
- Among cumulative AIDS cases as of 2000, 45% are associated with IDU;
- Among AIDS cases diagnosed in 1999, 33% are associated with IDU.

Various recent serosurveys indicate sustained risks for HIV among IDUs—HIV seroprevalence was:

- 8% in 1999 among 87 STD Clinic patients who are IDU;
- 16.1% in 1999 among 217 drug treatment center patients who are IDU (14.5% among males and 22.7% among females);
- 23.2% in 1999 among 56 IDU who also used crack.

Table 5 *continued*

*Assessment of
Populations with
Special Needs*

*Injecting Drug Users
(IDUs)*

Table 5 continued on next page

Table 5 *continued*

*Assessment of
Populations with
Special Needs*

*Men of color who
have sex with men*

Men of color who have sex with men

1. Estimated number of persons in this population (regardless of HIV status)

91,287-255,603

2. Estimated number of persons in this population living with AIDS

6,373 (excludes MSM/IDU)

3. Estimated number of persons in this population with HIV infection (including AIDS)

21,037

4. Estimated HIV prevalence rate for this population

8-23% (8,230-23,045:100,000)

5. Description of the population, including geographic distribution in the EMA, income level, language barriers, and other characteristics

MSM of color comprise between 1-3% of the overall population, and are thought to be geographically distributed within the EMA in patterns that are similar both to those of people in color and to MSM in general. Using AIDS case rates among MSM as a proxy measure, MSM are concentrated (above the 80th percentile for NYC) in many areas of Manhattan (63% of zip codes), as well as pockets in the Bronx (1 of 25 [4%] zip codes, Brooklyn (3 of 37 [8%] of zip codes), Queens (5 of 62 [8%] zip codes). People of color comprise a majority in 76% of Bronx, 51% of Brooklyn, 44% of Manhattan, and 42% of Queens. Nationally, gay men earn less than their heterosexual counterparts (in one national survey, 81% of gay men, compared to 65% of heterosexual men, earned less than \$25,000), though household income for male same-sex couples is slightly higher than for heterosexual couples – the degree to which these data may apply to the New York EMA is unknown. Poverty rates among people of color generally are substantially higher than among whites.

In a 1998 survey of over 7,000 men who have sex with men in New York City (document 128), gay and bisexual men are testing for HIV at much higher rates than New Yorkers in general. However, rates and place of testing change with age and race/ethnicity. Almost 89% of all men surveyed said they had taken an HIV test. Roughly one-tenth (11%) of the men surveyed reported unprotected anal intercourse with someone of unknown/different HIV status in the past year. The large majority (89%) of Black men surveyed do not report unprotected anal intercourse with someone whose HIV status is unknown or different (128:21). Of the men having unprotected anal intercourse with someone whose status was unknown/different, Latinos were significantly less likely to know their status than Black men, Asian/Pacific Islander man, or white men (128:21).

Less than half of the participants (42%) were men of color; so the sample under-represents men of color. Blacks and Latinos were twice

as likely to have tested in a hospital; Asian/Pacific Islander men were less likely to have testing than other races; men under 25 and men over 59 were less likely to have tested. Black men reported the highest HIV rates (17%), followed by Latinos (15%), whites (13%), and Asian/Pacific Islander men (2%) (128:6).

Table 5 *continued*

Assessment of Populations with Special Needs

Men of color who have sex with men

6. HIV infection and risk trends in this population

While AIDS incidence among MSM overall has decreased since 1993, the decline began later (1996) and was less pronounced among MSM of color. Risk for HIV infection is especially high among young men who have sex with men (YMSM). Among 3,492 YMSM ages 15-22 in the Young Men's Survey Phase I between 1994-1998 in seven cities (541 in NYC), HIV seroprevalence was highest in NYC (12.1% compared to 7.2% overall), and was higher among blacks (18.4%), Latinos (8.8%), and men of mixed race (16.7%), than among whites (3.1%). A high prevalence (46%) of unprotected anal sex during the preceding six months was also noted among these young men. Annual HIV incidence among the cohort was 7.6% (compared to 2.6% overall). Among all seven cities, HIV incidence was highest among blacks (4.0%) and persons of mixed race (5.4%), and was similar between homosexual and bisexual men. Recent risk behaviors associated with high HIV incidence were having >5 male sex partners, having unprotected anal sex with men, or having injected drugs.

In the Young Men's Survey Phase II, which enrolled men ages 23-29 in six of the seven original cities, HIV seroprevalence was 17% in NYC (compared to 13% overall), and was significantly higher among blacks (33% NYC, 32% overall) and Hispanics (14% overall and NYC) than whites (7% overall, 2% NYC). Among all six cities participating, overall HIV incidence was 4.4%; 2.5% among whites, 3.5% among Hispanics, and 14.7% among blacks.

In NYC:

- Among persons living with AIDS in 2000, 6,373 (19%) are MSM of color
- Among cumulative AIDS cases as of 2000, 18, 430 (15%) are among MSM of color
- Among AIDS cases diagnosed in 1999, 564 (13%) were among MSM of color

While AIDS is the fifth leading cause of death overall, it is the third leading cause of death among blacks and Puerto Rican men, and the leading cause of death among all men ages 25-44. Though recently, AIDS mortality has declined overall, among those with AIDS in NYC in 1998, blacks were nearly one and one-half times more likely than Hispanics and more than twice as likely than whites to die from AIDS

Table 5 continued on next page

Table 5 *continued*

*Assessment of
Populations with
Special Needs*

*White (Anglo)
men who have
sex with men*

White (Anglo) men who have sex with men

1. Estimated number of persons in this population (regardless of HIV status)

87,019-243,654

2. Estimated number of persons in this population living with AIDS

5,807 (excludes MSM/IDU)

3. Estimated number of persons in this population with HIV infection (including AIDS)

19,180

4. Estimated HIV prevalence rate for this population

8-22% (7,871-22,041:100,000)

5. Description of the population, including geographic distribution in the EMA, income level, language barriers, and other characteristics

White/Anglo MSM comprise between 1-3% of the overall population, and are thought to be geographically distributed within the EMA in patterns that are similar both to whites and MSM generally. Using AIDS case rates among MSM as a proxy measure, MSM are concentrated (above the 80th percentile for NYC) in many areas of Manhattan (63% of zip codes), as well as pockets in the Bronx (1 of 25 [4%] zip codes), Brooklyn (3 of 37 [8%] zip codes), Queens (5 of 62 [8%] zip codes). Whites comprise a majority in 24% of Bronx, 49% of Brooklyn, 56% of Manhattan, and 58% of Queens. Nationally, gay men earn less than their heterosexual counterparts (in one national survey, 81% of gay men, compared to 65% of heterosexual men, earned less than \$25,000), though household income for male same-sex couples is slightly higher than for heterosexual couples – the degree to which these data may apply to the New York EMA is unknown.

See section above on men of color who have sex with men for data on a 1998 sexual health and history survey of 7,000 New York City men. In addition, white men surveyed were more likely to use illegal drugs during sex than non-white men (128:21). Men combining sex and drugs were significantly more likely to have unprotected anal intercourse with someone of unknown/different status (128:21). White men surveyed were more likely to use drugs during sex than non-whites (128:19).

6. HIV infection and risk trends in this population

While AIDS incidence among MSM overall has decreased since 1993, risk for HIV/AIDS among all MSM remains substantial. Risk for HIV infection is especially high among young men who have sex with men (YMSM) – among 541 YMSM ages 15-22 in the Young Men’s Survey Phase I between 1994-1998, HIV seroprevalence was 3.1% among whites, compared to 12.1% overall. A high prevalence (46%) of unprotected anal sex during the preceding six months was also noted among these young men. Annual HIV incidence among this cohort was 7.6%--recent risk behaviors associated with high HIV incidence were having >5 male sex partners, having unprotected anal sex with men, or having injected drugs.

In the Young Men’s Survey Phase II, which enrolled men ages 23-29, HIV seroprevalence was 17%, and was 2% among whites. Among all six cities participating, overall HIV incidence was 4.4% -- 2.5% among whites.

In NYC:

- Among person living with AIDS in 2000, 5,807 (17%) are white/Anglo MSM
- Among cumulative AIDS cases as of 2000, 19,427 (16%) are among white/Anglo MSM
- Among AIDS cases diagnosed in 1999, 320 (7%) were among white/Anglo MSM

In recent serosurveys, HIV prevalence indicates sustained risks for HIV among white/Anglo MSM – among 1999 STD Clinic patients, 11% were seropositive.

Though recently, AIDS mortality has declined overall, it remains the leading cause of death among men ages 25-44, and the fifth leading cause of death overall.

Table 5 *continued*

Assessment of Populations with Special Needs

White (Anglo) men who have sex with men

Table 5 continued on next page

Table 5 *continued*

*Assessment of
Populations with
Special Needs*

*Women of child-
bearing years
(13 years and older)*

Women of child-bearing years (13 years and older)

1. Estimated number of persons in this population (regardless of HIV status)

4,069,518

2. Estimated number of persons in this population living with AIDS

12,527

3. Estimated number of persons in this population with HIV infection (including AIDS)

40,274

4. Estimated HIV prevalence rate for this population

0.9% (990:100,00)

*5. Description of the population, including geographic distribution in the EMA,
income level, language barriers, and other characteristics*

Women of childbearing age comprise approximately 44% of the overall population, and are uniformly distributed geographically within the EMA; women have lower incomes than men, however –among persons with income below poverty, the majority (58%) are women. The impact of AIDS among women is not uniformly distributed – using female HIV discharges as a proxy measure, women with HIV are concentrated (above 80th percentile for NYC) in the Bronx (56% of zip codes) and Manhattan (34%), with pockets in Brooklyn (6 of 37 [16%] zip codes and Queens (1 of 62 [2%] of zip codes).

According to CHAIN (33:9-14, 6/2000), more than half of women with HIV/AIDS who participated in the survey lack the informal support often associated with a live-in partner. Over 1/3 of female participants report no live-in partner and 1/4 (26%) report a non-live-in partner. More than 1/3 (33%) live with at least one child, and 1/5 (19%) are separated from all of their non-adult children. The vast majority (85%) are not currently working. Women surveyed who live in group quarters are worse off financially compared to women who live in any other family setting.

6. HIV infection and risk trends in this population

The proportion of AIDS cases diagnosed among women has increased every year, and continues to increase at a rate that, if sustained, will result in 50% of AIDS cases being diagnosed in 2010 among women. AIDS cases rates for women are substantially higher for women of color - in 1999, case rates (per 100,000) were 77.8 for black women, 46.5 for Hispanic women, and 5.6 for white women. Of particular concern, among cumulative heterosexual AIDS cases among women, 60% are associated with transmission from a drug-using partner. In NYC

- Among person living with AIDS in 2000, 12,611 (27%) are females;
- Among cumulative AIDS cases of 2000, 29,254 (24%) are among females;
- Among AIDS cases diagnosed in 2000, 1,426 (31%) were among females; in various serosurveys, HIV prevalence indicates sharply varying risks for HIV among females in different subpopulations:
 - 2.7% in 1999 among 72,810 NYCDOH Public Health Laboratories samples submitted by women;
 - 2.0% in 1999 among 1,632 female NYC STD Clinic patients (2.8% of black, 1.2% of Hispanic, 0.4% of white);
 - 18.6% in 1999 among 370 female NYC drug treatment center patients (18.7% of black, 22.4% of Hispanic, 4.3% of white);
 - 7.2% in 1999 among 291 female NYC chest clinic patients with TB;
 - 0.2% in 1998 among 1,744 female military recruits in NYC;
 - 18.1% in 1998 among 1,807 female NYC jail entrants (21.2% of black, 13.6% Hispanic, 12.2% of white);
 - 0.52% in 2000 among 134,624 women giving birth in the EMA;
 - 0.7% in 1997 among 6,090 women seeking abortions in NYC.

AIDS is the leading cause of death among women ages 25-44 in NYC, and the fifth leading cause of death overall. Though recently, AIDS mortality has declined overall, among those with AIDS in NYC in 1998, women were 34% more likely to die from AIDS than men; those who acquired AIDS heterosexually were nearly one and one-half times more likely to die than those who acquired HIV from intravenous drug use or other methods.

According to CHAIN (33:14, 6/2000), 1/4 (24%) of women with HIV/AIDS who participated in the survey reported never having had any substance abuse problems, while more than half (53%) reported a former substance abuse problem, and more than 1/5 (22%) reported a current substance abuse problem. More than 1/3 (37%) reported ever injecting drugs, and about 1/4 (24%) reported ever exchanging sex for money or drugs.

Table 5 *continued*
Assessment of Populations with Special Needs

Women of child-bearing years (13 years and older)

Table 5 continued on next page

Table 5 *continued*

*Assessment of
Populations with
Special Needs*

*Other Substance
Users*

Other Substance Users

1. Estimated number of persons in this population (regardless of HIV status)

821,614 (763,293 adults and 58,321 adolescents aged 12-17) problems drinkers or non-narcotic drug users in need of treatment

2. Estimated number of persons in this population living with AIDS

Unknown

3. Estimated number of persons in this population with HIV infection (including AIDS)

26,584

4. Estimated HIV prevalence rate for this population

3% (3,235:100,000)

5. Description of the population, including geographic distribution in the EMA, income level, language barriers, and other characteristics

Substance abuse is widespread in the New York EMA and continues to be a dominant factor in the New York HIV epidemic. Based on OASAS estimates, substance users in need of treatment comprise 10.6% of the adult population. Rates of non-injection drug use (as indicated by hospital discharges, emergency room mentions, arrests, deaths, and drug treatment admissions associated with cocaine, marijuana, psychoactive prescriptions drugs, stimulants, hallucinogens, and alcohol) vary markedly and often parallel AIDS prevalence rates. For example, rates of substance abuse (as measured by cocaine-related hospital discharges) are especially high above 80th percentile for NYC) in 40% of Bronx County, 11% of Brooklyn, 41% of Manhattan, and 5% of Queens zip codes.

Polydrug use is common – OASAS estimates that 13.4% of persons in need of alcohol treatment were also in need of substance abuse treatment, while 51.6% of persons in need of substance abuse treatment were also in need of alcohol treatment. OASAS also estimates that among persons with alcohol or substance abuse (ASA) problems, only 20-25% will avail themselves of treatment if available. Among those receiving treatment services (ASA) in the EMA in 1999:

- 74% are males and 26% are females;
- 44% are black, 30% are Hispanic, and 23% are white;
- 4% are <18, 8% are 18-24, 28% are 25-34, 39% are 35-44, 16% are 45-54, and 5% are >55;
- 6% are veterans, 16% are homeless, 54% are high school graduates, 16% are employed, 39% are criminal justice clients, 17% are physically impaired, 14% are mentally ill, 9% (of women live with dependent children), and 1% (of women) are pregnant.

- 73% have previously received ASA treatment, and 41% are children of alcohol or substance abusers;
- 15% receive wages or salary, 37% receive public entitlements, and 28% have no income;
- 46% are admitted for treatment for abuse of alcohol, 16% for heroin, 9% for Marajauna, 10% for crack, 6% for cocaine, and 2% for other (barbiturates, methamphetamines, PCP, hallucinogens, tranquilizers, inhalants, and other drugs).
- Among persons admitted for cocaine treatment, 67% are associated with smoking crack and 30% inhaling (snorting): crack users are more likely than those who snort cocaine to be female (42% vs. 27%), black (71% vs. 41%), readmissions to treatment (78% vs. 66%), and without income (35% vs. 25%). Among those admitted for marijuana use, the vast majority were male (80%) and almost 40% were younger than 21. More than half (56%) were black, 32% were Hispanic, and 9% were white. Alcohol was the secondary drug of abuse for 44%.

See section above on men of color who have sex with men for data on a 1998 sexual health and history survey of 7,000 New York City men. In addition, nearly half of participants (49%) reported using alcohol or drugs and more than one-fifth (22%) reported use of cocaine, Ecstasy, "crystal," "K", or crack during the last year (128:19). Men combining sex and drugs were significantly more likely to have unprotected anal intercourse with someone of unknown/different status (128:21).

HIV incidence and prevalence associated with non-injection drug use is especially difficult to ascertain, but appears to be far higher among women because of an increased risk associated with heterosexual transmission. Among 1,310 persons seeking drug treatment in 1999 who reported no previous injecting drug use, 10.1% were HIV-infected (compared to 16.1% IDU) – rates were significantly higher among females (18.1%) than males (7.4%). Among 364 reporting no injecting drug or crack use, 8.0% were HIV infected.

AOD users comprise a significant proportion of person with HIV in the EMA – 22% report active use within the previous 12 months. In FY00, among 56,741 individuals filing HIV-related Medicaid claims, 26% also filed claims for treatment of substance abuse. High-risk sexual practices among drug users have also been associated with crack cocaine users, men and women trading sex for drugs, homeless youth, and MSM using cocaine. Use of so-called "club drugs" among MSM attending NYC nightclubs has also been associated with high levels of sexual HIV risk behaviors.

Table 5 *continued*
Assessment of Populations with Special Needs

Other Substance Users

Table 5 continued on next page

Table 5 *continued*

*Assessment of
Populations with
Special Needs*

*Mentally ill
chemical abusers*

Mentally ill chemical abusers

1. *Estimated number of persons in this population (regardless of HIV status)*

190,000 (NYC)

2. *Estimated number of persons in this population living with AIDS*

Unknown

3. *Estimated number of persons in this population with HIV infection (including AIDS)*

13,070 (NYC)

4. *Estimated HIV prevalence rate for this population*

6.8% (6,879:100,000)

5. *Description of the population, including geographic distribution in the EMA, income level, language barriers, and other characteristics*

(See Injecting Drug Users Other substance users above.)

6. *HIV infection and risk trends in this population*

MICA individuals comprise a significant proportion of persons with HIV in the EMA – among the CHAIN cohort, 9% report active drug use within the previous 12 months and score “low-low” (below 37.0) on a Standard Mental Health Assessment II, the MOS Mental component Summary Scale (MCS-SF36), indicating symptoms consistent with a psychiatric diagnosis. In FY00, among 5,741 individuals filing HIV-related Medicaid claims, 18% also filed claims for treatment of mental illness, while 26% also filed claims for substance abuse treatment. Mental illness may impede access to health or social services, and can foster behaviors that contribute to HIV transmission. Mentally ill chemical abusers (MICA) often engage in a variety of risk behaviors; a 1994 NYC study found that 23% of MICA patients were HIV-infected. Treatment for mental illness may reduce risk behaviors – those receiving mental health services have lower rates of high-risk sex and drug use behaviors. (See also Injecting Drug Users and Other Substance Users above.)

Table 5 continued on next page

Immigrants and undocumented persons*1. Estimated number of persons in this population (regardless of HIV status)*

3,725,694

2. Estimated number of persons in this population living with AIDS

5,445 (NYC)

(Among live AIDS cases in NYC for whom country of birth is known; note that for 36% of all cases, country of birth is unknown.)

3. Estimated number of persons in this population with HIV infection (including AIDS)

Unknown

4. Estimated HIV prevalence rate for this population

Unknown

5. Description of the population, including geographic distribution in the EMA, income level, language barriers, and other characteristics

As of the 1990 US Census, 27% of all EMA residents (2.3 million people) were foreign born. Since then, however, the proportion of foreign-born residents has increased dramatically, by as much as 43%. Recent estimates suggest that 40% of the NYC (where 91% of EMA immigrants reside) population is foreign-born, with the Dominican Republic currently the largest source of immigrants, followed by the former Soviet Union, China, Jamaica, and Guyana. Over 1 million immigrants arrived in NYC between 1990-2000 and the influx is expected to continue unabated. NYC receives 14% of all immigrants to the United States, in excess of 115,000 annually. Seventeen percent are refugees or asylees.

Geographic distribution of foreign-born persons varies substantially – 31% and 29% of all EMA immigrants live in Brooklyn and Queens, respectively. Recent immigrants are heavily concentrated (>1,750/annually) in 3 of 41 (7%) zip codes in Brooklyn. Queens residents alone comprise 167 nationalities and speak 116 languages. Among the fastest growing immigrant groups are the former Soviet Union, Mexico, India, Pakistan, and Bangladesh. Among legal immigrants, 40% are uninsured – among undocumented persons, the proportion is far higher.

Table 5 *continued*

Assessment of Populations with Special Needs

Immigrants and undocumented persons

Table 5 continued on next page

Table 5 *continued*

*Assessment of
Populations with
Special Needs*

*Immigrants and
undocumented
persons*

6. HIV infection and risk trends in this population

Data reflecting HIV trends among immigrants are scarce – in 2000, among live AIDS cases for which country of origin was known (64% of total), 18% are foreign-born. Among those, more than half are from Haiti (18%), the Dominican republic (10%), Jamaica (5%), Columbia (4%), Mexico (4%), Trinidad/Tobago (4%), Ecuador (3%), or Cuba (3%). As HIV-infected persons are prohibited from legally immigrating, overall HIV seroprevalence may be lower among the foreign-born (28.7:100,000, compared to 9.7:100,000 among US born), foreign born TB cases are much less likely to be HIV infected (9.6%) than US-born TB cases (31%).

Table 5 continued on next page

Homeless population in shelters, SROs, and “on the street”

1. *Estimated number of persons in this population (regardless of HIV status)*
62,633 (1998 annual NYUC shelter utilization. Average NYC daily census – 22,994)
2. *Estimated number of persons in this population living with AIDS*
Unknown
3. *Estimated number of persons in this population with HIV infection (including AIDS)*
11,954
4. *Estimated HIV prevalence rate for this population*
19% (18,974:100,000)
5. *Description of the population, including geographic distribution in the EMA, income level, language barriers, and other characteristics*

Quantifying homelessness poses substantial methodological challenges. Estimates are often based upon shelter utilization, but the typical experience of homeless shelter use consists of one or two episodes, after which three quarters of homeless persons do not return. In NYC in 1998, an estimated 62,633 persons utilized homeless shelters; the average length –of-stay was 125 days. In July 2001, the average daily census was comprised of 28,029 individuals: 7,734 single adults (5,682 men and 1,692 women) and 6,252 families (20,295 individuals, including 11,594 children). Blacks and Latinos are disproportionately represented – among adult shelter residents, 62% are black, 24% are Latino, and 8% were white. Among homeless families, the majority (61%) named a previous address in one of only four neighborhoods: Harlem (15% of the total), South Bronx (25%), Bedford Stuyvesant and East New York (21% combined). Over 26% report living on the street prior to entering shelters. Approximately 90% of families in NYC shelters are headed by single women.

A substantial number are at imminent risk of becoming homeless, due to potential eviction, very low-income and high rent burden, substandard housing, overcrowded living conditions, and recent homelessness. Housing conditions are worse for NYC’s black and Latino residents. Compared to 5% of white residents who live in crowded housing, 11% of blacks, 10% of Puerto Ricans, 20% of non Puerto Rican Latinos, and 22% of Asians live in crowded housing conditions. Black and Latino renters were disproportionately represented in substandard housing, with black renters occupying 37% and Latinos occupying 36% of all “physically poor” units (compared to 26% and 27% of all rental units, respectively).

Table 5 *continued*

Assessment of Populations with Special Needs

Homeless population in shelters, SROs, and “on the street”

Table 5 continued on next page

Table 5 *continued*

*Assessment of
Populations with
Special Needs*

*Homeless population
in shelters, SROs,
and "on the street"*

6. HIV infection and risk trends in this population

Among 18,864 hospital admissions among homeless persons in NYC in 1992-1993, 15% had a principal (8.1%) or coexisting (6.4%) AIDS diagnosis. The New York EMA's 1993 Baseline Needs Assessment estimated that 15-30% of the City's homeless are HIV-infected. Health providers describe persons already homeless as being at "extreme risk" of HIV infection. Drug use is endemic in the population, both as a cause and a response to homelessness. Many homeless persons are sexually active and are likely to have partners who have histories of high-risk drug use. In addition, many persons who are homeless engage in heterosexual and homosexual sex for survival, including sex for money, food, shelter and drugs. This population includes an estimated 20,000 homeless adolescents, many of whom engage in sex for survival.

Table 5 continued on next page

Detained inmates and recently released inmates

1. Estimated number of persons in this population (regardless of HIV status)	+139,085
2. Estimated number of persons in this population living with AIDS	Unknown
3. Estimated number of persons in this population with HIV infection (including AIDS)	5,000-13,000
4. Estimated HIV prevalence rate for this population	7-10%
5. Description of the population, including geographic distribution in the EMA, income level, language barriers, and other characteristics	

Table 5 *continued*

Assessment of Populations with Special Needs

Detained inmates and recently released inmates

State and local correctional agencies detain and otherwise supervise persons in a variety of settings.

- In 2000, the NYC Department of Correction admitted 84,497 adult (>16 years) inmates. Of those 23,405 (28%) were admitted more than once during the year. (Fifty percent of the total 124,501 admissions were persons who had been previously detained during the previous 12 months.) Although average length of stay was 46 days, 54% of inmates were released within seven days. Average daily census in 2000 was 15,530. The majority of inmates are housed in 10 facilities on Rikers Island; the remainder are in six borough houses of detention (with a combined capacity of 4,000), 15 court detention facilities, or four hospital prison wards. Among all inmates, 90% are males; 56% are African American, 35% are Latino, and 7% are white. The average inmate age is 31. Among all jail entrants, 23% reside in Brooklyn, 18% in the Bronx, 13% in Manhattan, and 10% in Queens. In 1998, 82% of female and 77% of male arrestees in NYC tested positive for drug use.
- The NYC Department of Probation admits approximately 25,000 persons to community-based supervision (in lieu of custody) annually. Probation sentences range from one or three years for misdemeanors to five years for felonies. At any given time, DOP supervises 60,000 adults and 4,000 juveniles.
- In FY01, the NYC Department of Juvenile Justice admitted 5,313 juvenile delinquents (young persons ages 7-15 charged with committing an act that if committed by an adult would be a crime) or juvenile offenders (young persons ages 13-15 charged with committing specific felonies that confer jurisdiction on adult courts to prosecute), 4,828 to secure and 485 to non-secure detention. Juvenile delinquents spent an average

Table 5 *continued**Assessment of
Populations with
Special Needs**Detained inmates
and recently
released inmates*

18 days in secure or 37 days in non-secure detention; juvenile offenders spent an average 29 days in secure detention, resulting in average daily censuses of 357 for secure and 140 for non-secure detention. Among those in secure detention, though their average age is 15, 55% read below seventh-grade level and 25% read below the fourth grade level. Among all juveniles detained, 84% are males; 63% are African-American, 31% are Hispanic, 3% are white, and 1% are Asian.

- As of January 2001, the NYS Department of Correctional Services prison system housed 70,153 inmates, of whom 66,874 (95%) are male and 3,279 (5%) are female. While 9% of system-wide inmates (7% of men and 52% of women) are housed within prison facilities located within the EMA, 74% of inmates system-wide were committed from New York City (44,557) or suburban New York City (7,252).
- In 2000, the NYS Department of Correctional Services discharged 12,789 inmates (92% male and 8% female) in the EMA, 95% of releasees were discharged in NYC. Of total discharges, 47% were for drug offenses, although the proportion was far higher for women (64%) than men; average age was 36 for women and 33 for men. Among all NYS inmates, 12.5% are foreign born, 65% are never married, 60% have one or more children, 6% are veterans, and 35% have a prior prison term. Thirty-one percent read below a 7th grade level, 47% have graduated from high school, and 9% are Spanish language dominant. Seventy-one percent (70% of men and 87% of women) are identified substance abusers-of those, 29% report abusing drugs, 53% report abusing drugs and alcohol, and 19% report abusing alcohol. Approximately ten percent of inmates are under psychiatric treatment or observation while incarcerated; among discharges, approximately 10% receive community mental health referrals.
- In 2000, the Westchester County Department of Correction admitted 8,848 persons (7,680 males and 1,168 females), resulting in an average daily census of 1,300. Of those, 23% are white, 48% are black, and 26% are Hispanic. Sixteen percent require in-house psychiatric treatment or observation, while 80% require mental health treatment in their discharge plan. Between 7-10% are HIV-infected.

6. HIV infection and risk trends in this population

HIV prevalence among New York State inmates is higher than in any other state. As of December 1999, 7,000 NYS inmates (9.7%) were known to be HIV positive, including 6,240 men (9%) and 760 women (22%), accounting for more than 25% of HIV-positive inmates in state or federal prisons in the country. Of those, 1,170 had AIDS.

While HIV seroprevalence among detained persons in NYC declined almost 50% between 1989 and 1998, it remains high, particularly among certain subpopulations – in 1998, HIV seroprevalence was:

- 9.7% overall
- 7.6 among males (8.1% among blacks, 7.1% among Hispanics, 5.6% among whites) and 18.1% among females (21.2% among blacks, 13.6% among Hispanics, 12.2% among whites)

As of June 1999, 1,165 NYC jail inmates (7%) were known to be HIV positive, accounting for nearly 30% of HIV-positive jail inmates in the 50 largest jurisdictions in the country.

Table 5 *continued*

Assessment of Populations with Special Needs

Detained inmates and recently released inmates

Source: Title I 2002 application, document 011:87-113 unless otherwise noted.

F. Poverty, Insurance Status and Co-morbidity Data

Table 6 presents co-morbidity data, including poverty and lack of insurance. The first part of the table presents information on co-morbidities in the general EMA, or in some cases the New York City, population. The second half of the table focuses on co-morbidities among CHAIN participants. The CHAIN data shows a decline over time in all co-morbidities.

Table 6. Co-Morbidity, Poverty and Insurance Status

Co-morbidity	Prevalence Within the General Population Within New York City
A	B
Tuberculosis	2000 EMA cases = 1,433 2000 EMA rate = 15.4:100,000 (among EMA population)
Syphilis (primary and secondary)	2000 EMA cases = 122 2000 EMA rate = 1.6:100,00 (among EMA adult population > 12)
Gonorrhea	2000 EMA cases = 12,025 2000 EMA rate = 155:100,000 (among EMA adult population > 12)
Chlamydia	2000 EMA cases = 23,751 (female) 2000 EMA rate = 575:100,000 (among female adult population > 12)
Intravenous Drug Users	2000 NYC estimate = + 160,000 2000 NYC rate = 2,172:100,000 (among NYC adult population > 12)
Other Substance Abuse (i.e., alcohol, methamphetamine, cocaine, inhalants)	2000 EMA estimate = 821,614 (763,293 adults and 58,321 adolescents aged 12-17) problem drinkers or non-narcotic drug users in need of treatment 2000 EMA rate = 10,589:100,000 (among EMA adult population > 12)
Homelessness	2000 NYC estimate = + 63,000 (annual) 2000 NYC rate = 787:100,000 (among total NYC population) 2000 EMA point prevalence (daily) = 26,538 2000 EMA daily rate = 285:100,000
Insurance status	Total # of uninsured = 1,425,078 Rate = 15,300:100,000
Poverty	Total # below 100% federal poverty level = 1,728,432 Rate = 18,577:100,000

Source: Title I 2002 application, document 011:85-86

Table 6. Co-Morbidity, Poverty and Insurance Status Among CHAIN Participants, Over Time

Co-morbidity	Percent at Wave 1 9/94-9/95	Percent at Wave 3 2/96-12/96	Percent at Wave 6 11/98-1/00
A	B	C	D
Tuberculosis	6	3	<1
STD	17	14	1
Current Drug User	36	37	19
Very Low Mental Health	36	29	27
Unstably Housed	37	23	16
Dual Diagnosis	14	13	7
Unstably Housed Drug Users	19	13	6
Multiply Diagnosed	6	2	1

Source: document 037:16

Assessment of Service Needs

A. Introduction

As is evident from the preceding sections, the HIV/AIDS epidemic in New York City disproportionately affects certain specific populations. For a variety of reasons, these populations are generally underserved. They tend to have greater difficulty in accessing existing HIV/AIDS health and social support services.

The special population categories examined in this needs assessment are based on variables of age (infants/children, youth, and older adults); co-morbidities (alcohol and other drugs and mentally ill/chemical abusers); HIV exposure categories (men of color and white men who have sex with men, and women); socioeconomic, cultural, and other characteristics (inmates/releasees, immigrants/undocumented, homeless, and unconnected to care).

The purpose of this section is to describe the needs of each of the special populations. Also presented are the services that have been targeted to meet these needs and to overcome the identified barriers to access.

B. Special needs, services, and disparities in access

Table 7 provides data describing the special needs of each of the identified special populations. The table also shows disparities that may exist between the services targeted to meet the needs of these populations and the degree to which services meet these needs. Using this table, the reader can identify special populations that have unmet service needs.

Note that barriers, which are often associated with needs and disparities, are presented in Table 12. Strategies for overcoming barriers are also indicated.

Table 8 identifies the number of Title I contracts that served individuals in one or more of 12 special populations in fiscal year 2000. Several Title I contracts target multiple special populations.

Table 9 shows data on the utilization of Title I services by service category for each of 10 special populations. To assist the reader in locating specific service categories, the categories have been grouped under major service headings: health, social services, housing, and harm reduction. The data presented in the table show the

reader the number of unduplicated new clients in each of the special population groups that have received services in each of the service categories. Data were not available for some special populations including infants/children, youth, and women.

Table 7: Special Needs, Targeted Services, and Disparities by Population

Population	Special Needs for Targeted Services	Disparities ⁵
A	B	C
Infants and Children	<p>18:4. Per CHAIN (12/2001), based on 1998 statistics more than 55% of living pediatric AIDS cases in NYC are attributable to the IDU of at least one parent.</p> <p>86:1 through 4. According to McClain & Associates (2/2002), Children who are not HIV+ receive permanency planning and other services after the loss of their parent. However, since Title I limits the funding of services for non-HIV infected individuals, agencies must find other funding sources to continue serving these children.</p>	
Youth	<p>57:not numbered. According to the Prevention Planning Group (2000), the following characteristics of participants should be considered in planning youth programs: bilingualism, court-involvement, sexual orientation, immigrant status, school status, income level, multi-system involvement, whether perinatally infected, homelessness, relationships of youth to their families, the HIV status of their families, sex worker status, substance use, and race/ethnicity.</p> <p>57:not numbered. According to the Prevention Planning Group (2000), although HIV prevalence among adolescents and young adults has declined steadily over the past decade, the most recent figures suggest that among Black and Latino</p>	

⁵ Caution should be used in drawing conclusions about disparities from this table. Sources for this column on disparities are limited to studies that specifically mentioned disparities for a specific population. Therefore, the lack of disparity data for a specific population in this table, while it accurately reflects the sources of the needs assessment, does not necessarily reflect the actual absence of current disparities for that population.

Table 7 *continued*

*Special Needs,
Targeted Services,
and Disparities
by Population*

Youth

AOD

Population	Special Needs for Targeted Services	Disparities⁵
A	B	C
Youth (continued)	<p>MSM, ages 15-22, and among young jail entrants, especially females, rates of HIV infection are substantially higher than among other groups of youth at risk. The vast majority of HIV infections among adolescents are sexually transmitted.</p> <p>65:2. According to a Housing Workgroup Y12 template (undated), subpopulations most affected by a lack of housing include adolescents and young adults.</p>	
AOD	<p>95:4&5. A 3/2000 NYAM study found AOD users at risk for co-morbidities including: skin infections, pneumonia, overdoses, mental illness, and hepatitis.</p> <p>18:4. Per CHAIN (12/2001), during any 6-9 month period, approximately 25% of participants with a drug history will change their drug use patterns, whether in the direction of "relapse" or "recovery".</p> <p>65:2. According to a Housing Workgroup Y12 template (undated), AODs are one subpopulation most affected by a lack of housing. Since public housing requires a period of drug-free time prior to receipt of housing, AODs may be particularly impacted.</p> <p>65:2. According to a Housing Workgroup Y12 template (undated), the AOD population needs housing that is: low threshold, safe, that provides voluntary on-site services.</p> <p>32:14. Per a CHAIN overview report (2000), only about half of the participants who have had AOD problems in the prior six months received treatment. Yet the majority of AOD users state that treatment is important to them.</p>	<p>41:3. Per CHAIN (5/1999), compared to other groups, HAART usage is lower among those who regularly use crack/ cocaine.</p> <p>18:4. Per CHAIN (12/2001), compared to those with a substance use history, those with no such history who are newly diagnosed make the transition to HIV+ services more smoothly, waiting a shorter time after initial diagnosis before seeking out care, and being more likely to have a referral rather than having to seek out service on their own.</p> <p>95:4&5. A 3/2000 NYAM study found AODs less likely to receive consistent HIV medical care than non-users because of the need to address daily survival issues and a perception (often correct) that they do not receive quality health care.</p>

Population	Special Needs for Targeted Services	Disparities ⁵
A	B	C
MSM	<p>50:19. Per CHAIN (4/1998), participants who are in private (versus Medicaid) managed care tend to be white, MSM, and have a higher income.</p> <p>56:20. Per the High Needs Index II, for Medicaid cost data, MSM have a disproportionate share of outpatient and pharmacy costs.</p>	
Women	<p>60:5&6. According to an AOD Y11 template (6/2000), of individuals tested for HIV upon incarceration 19% of women (compared to 7% of men) tested positive.</p> <p>65:2. According to a Housing Workgroup Y12 template (undated), subpopulations most affected by a lack of housing include women with children.</p> <p>33:3. Per CHAIN (6/2000), 30% of women expressed a need for housing and housing services.</p> <p>60:5&6. According to an AOD Y11 template (6/2000), high sero-positive rates for incarcerated women emphasize the need for HIV related education and services in prison, including drug treatment.</p> <p>54:7. According to a Community Forum Report (11/2000), there is a need for services focusing on women's reproductive health.</p> <p>54:9. According to a Community Forum Report (11/2000), there is a need for specialized housing for women.</p> <p>92:7. Most residential treatment programs are not able to provide services to women with children. This specialized service is needed.</p> <p>76:2. According to a Social Services Y11 template (7/2001),</p>	<p>41:3. Per CHAIN (5/1999), compared to other groups, HAART usage is lower among individuals with three or more dependent children.</p> <p>44:10 through 24. Per CHAIN (5/1999), men are more likely to report using HAART exactly (68%) than is true of women (56%).</p> <p>38:10 & 11. Per CHAIN (4/2000), female participants are less likely to be on HAART than the general population.</p> <p>43:13. Per CHAIN (5/1999), men tend to report better health functioning than women and individuals who believe in their ability to manage their own health often report better health behaviors and outcomes.</p>

Table 7 *continued*

Special Needs, Targeted Services, and Disparities by Population

MSM

Women

Table 7 *continued*

*Special Needs,
Targeted Services,
and Disparities
by Population*

Women

Inmates/releasees

Population	Special Needs for Targeted Services	Disparities ⁵
A	B	C
Women (continued)	<p>several large congregate meal providers report the need for child care at program sites as a way to better serve women.</p>	
	<p>25:18. Per CHAIN (11/2001) women participants were more likely to report using CARE Act funded health services such as primary medical care, health, and dental services than was true of participants more generally.</p>	
	<p>33:15-16. Per CHAIN (6/2000) the rates of women who reported a need for integrated medical care are high (38%) although the differences among the various family types are not statistically significant. More than 1/4 (27%) of women across family types report the need for a considerate medical provider. Women who live in group quarters consider treatment for alcohol or drug problems moderately, considerably, or extremely important (83%).</p>	
Inmates/ releasees	<p>60:5&6. According to an AOD Y11 template (6/2000), of individuals tested for HIV upon incarceration 19% of women and 7% of men tested positive.</p>	
	<p>65:2. According to a Housing Workgroup Y12 template (undated), subpopulations most affected by a lack of housing include inmates/releasees.</p>	
	<p>60:5&6. According to an AOD Y11 template (6/2000), high sero-positive rates for the incarcerated emphasize the need for HIV related education and services in prison, including drug treatment.</p>	
	<p>108:37. According to the Title I 2002 RFP, discharge planning and case management are provided at Riker's Island for detainees and prisoners.</p>	

Population	Special Needs for Targeted Services	Disparities ⁵
A	B	C
MICAs	<p>32:14. Per a CHAIN overview report (2000), many clients receiving low mental health scores on a standardized test do not perceive the need for mental health services.</p> <p>68:5. According to a Y12 Housing template (7/2001), many PLWHA living in enhanced supportive housing programs are MICAs.</p> <p>65:2. According to a Housing Workgroup Y12 template (undated), subpopulations most affected by a lack of housing include the mentally ill/substance abuser.</p> <p>30:12 through 16. Per CHAIN (6/2000), extrapolating from CHAIN data, Columbia researchers estimate that 14-25% of PLWHA in NYC are seriously and persistently mentally ill.</p> <p>30:20. Per CHAIN (6/2000), mental health services are accessed by participants more often at voluntary hospitals with Designated AIDS Centers (22%) or in private physician offices (19%). Community-based social services organizations provided the bulk of social worker or case manager counseling services. 97% of clients who received any type of mental health services had a referral to the service. More referrals were from a medical provider (58%).</p> <p>30:16. Per CHAIN (6/2000), among those with low mental health scores, approximately 53% of all participants have received mental health services. Approximately 1/3rd of these received services from a mental health professional; 1/3rd from a support group, and 1/4th from a social worker or case manager.</p>	<p>47:11. Per CHAIN's 1999 Unconnected Revisited, the unconnected that the research team were able to locate were mostly homeless, mentally ill, substance users, or a combination of more than one of these.</p> <p>41:3. Per CHAIN (5/1999), compared to others HAART usage is lower among those who have low mental functioning.</p>

Table 7 *continued*

Special Needs, Targeted Services, and Disparities by Population

MICAs

Table 7 *continued*
*Special Needs,
 Targeted Services,
 and Disparities
 by Population*

*Immigrants/
 undocumented*

Homeless

Population	Special Needs for Targeted Services	Disparities⁵
A	B	C
Immigrants/ undocumented	<p>90:23. According to Sociomedical Resource Associates (12/2001), social networks in immigrant communities play a critical role in directing new arrivals to appropriate services.</p> <p>90:23. According to Sociomedical Resource Associates (12/2001), Hispanic sub-populations are so diverse that it is difficult to generalize regarding their cultural issues. Cultural practices unique to the country of origin, norms of their community of residence in the US, gender roles, immigration status, and health beliefs all determine what services are accessed, when, and by whom [p5].</p> <p>99:4. According to Sociomedical Resource Associates (12/2001), many immigrants learn of their HIV status when they are sick and go to the hospital; many immigrant, women discover their infection status in prenatal testing [p27].</p> <p>65:2. According to a Housing Workgroup Y12 template (undated), subpopulations most affected by a lack of housing include immigrants.</p>	
Homeless	<p>41:3. Per CHAIN (5/1999), compared to others HAART usage is lower among those in (or at risk of) unstable housing.</p> <p>37:3, Per CHAIN (5/2000), amongst participants, men, drug users, and residents of the Bronx and Manhattan are all more likely to have persistent problems with unstable housing.</p> <p>28:2 through 11. Per CHAIN (5/2000), approximately 60% of participants have experienced at least one episode of homelessness, or</p>	<p>109:2 through 8. Per CHAIN (11/2001) participants who are homeless are more likely to report poor physical functioning (58%) than those who are stably housed (50%). They are also more likely to have very low mental health functioning (32% compared to 27%).</p> <p>41:3. Per CHAIN (5/1999), compared to others HAART usage is lower among those who are homeless or at immediate risk of becoming homeless.</p>

Population	Special Needs for Targeted Services	Disparities ⁵
A	B	C
Homeless (continued)	<p>unstable/inadequate housing. At any point in time, 20-25% of PLWHA in NYC are unstably housed. Approximately 25% of formerly homeless persons return to homelessness or unstable housing within six months of being successfully placed in housing. The average length of time in terms of maintaining stable housing is about 18 months. Factors which decrease the likelihood of being stably housed include low mental health scores and being a frequent drug user.</p> <p>28:2 through 11. Per CHAIN (5/2000), housing services improve a person's chances of securing stable, adequate housing and reduce the risk of losing housing. Rental subsidy is the strongest predictor of securing and maintaining housing. Supportive services (case management, mental health and/or drug treatment) are also important in helping to achieve housing stability.</p> <p>126:2 Per the HIV/AIDS Services Administration (HASA), a total of 6,329 units of housing were provided at a total cost of \$84.3 million during fiscal year 2001. Specifically, 4,279 units of scatter site housing (cost of \$48.0 million) and 2,050 units of congregate housing (cost of \$36.3 million) were reported.</p>	<p>44: 10 through 24. Per CHAIN (5/1999), the stably housed are almost five times more likely than the unstably housed to report continuous use of HAART.</p> <p>23:6 & 7. Per CHAIN (7/2001), 13% of participants who are not stably housed have no medical care (compared to 3% for the stably housed) and 32% have inadequate medical care (compared to 23% for the stably housed). 32% of the unstably housed have experienced an interruption in medical care, compared to 25% for the stably housed. 10% of the unstably housed lack health insurance, compared to 3% for the stably housed. 32% of the unstably housed were delayed for three months or more in seeking HIV care compared to 20% who were stably housed. People with housing needs who get assistance are almost four times more likely to enter into medical care than those who do not get assistance. If the assistance is housing-focused case management this figure leaps to 10 times.</p>

Table 7 *continued**Special Needs, Targeted Services, and Disparities by Population**Homeless*

Sources: Document numbers are indicated for each entry.

Table 8: Title I Contracts Targeting Special Populations,⁶ March 2000-February 2001

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
	Adolescent	Children	Adolescent	AOD	MSM of Color	MSM white	Women	Inmate Releasee	MICA	Immigrants/ undocumented	Homeless	Seriously Mentally Ill	Trans-gender	Other	Total
Adult Day Treatment				1											1
Access to Early Intervention										1					1
Air Bridge Project														3	3
Buddy Services							1								1
Client Advocacy				1			2							1	4
Case Management				1	1	1	1	2		3	2		1	4	16
Custody Planning														2	2
Dental Care		1	1												2
Family-Centered Harm Reduction				6			2		1	1			1	1	12
Harm Reduction/Recovery Readiness/ Relapse Prevention				21	1	1	4	6	1	2	5	1	2	4	48
Hepatitis Screening/ Services				1											1
Home Care		2	2	1			1		1	1		1		3	12
Housing Referral/Placement											1				1
Mental Health for Adults							1					1	1		3
Mental Health for Populations/Special Needs				1				1	4			3			9
Mental Health for Families/Children/ Adolescents		3	7	2	3	4	5	2	1	4	3		3	6	43
Outpatient Medical Care		2	2	1			1			2	2			2	12
Prison Project								3							3
Supportive Counseling			1	2		1	2	1	1						8
Treatment Adherence				2				1			1			1	5
Treatment Education										1				2	3
TB Services														3	3
Total		8	13	40	5	7	17	19	9	15	14	6	8	32	193

Source: Document 080: Ryan White Title I Program Monitoring Report to the New York City Department of Health, March 2000-February 2001 (February 2002), Medical and Health Research Association of New York.

⁶ Data in this table do not necessarily reflect all special populations served by Title I-funded agencies.

Table 9: New Title I Clients⁷ by Special Population

Service Category	A											Other											
	B	C	D	E	F	G	H	I	J	K	L	TB	Physically Disabled	Mentally Disabled	Homeless	Immigrants/ Undocumented	MICA	Inmates/ Releasees	MSM white	MSM of Color	AOD		
Health Programs																							
Air Bridge Project	57	5	51	9	6	21	11	0	1	6	5												
Outpatient Medical Care	682	221	435	77	135	85	130	6	8	19	203												
Home health care	65	41	56	1	2	5	7	0	0	1	104												
Treatment Education	77	19	23	10	2	13	1	1	0	0	7												
TB Services	58	7	4	4	2	6	8	0	0	32	4												
Dental Care	105	7	13	31	41	2	1	1	1	6	11												
Adult Day Treatment	59	2	2	31	5	2	20	0	0	0	0												
Social Services																							
Case Management	606	269	222	322	52	182	263	6	78	43	372												
Client Advocacy	322	103	164	56	43	217	16	103	162	142	203												
Food / Nutrition	625	267	260	25	11	16	58	16	13	76	24												
Custody Planning/Transitional Support	13	0	0	0	0	1	0	0	0	0	0												
Transportation	0	0	0	0	0	0	0	0	0	0	0												
Supportive Counseling	110	9	38	77	17	15	42	1	2	0	5												
Promoting Access to Early Intervention	309	10	1	20	85	169	37	0	33	6	12												
Buddy/Respite Services	18	46	76	3	1	1	1	18	1	32	0												
Housing Programs																							
Housing Placement Assistance	6	0	3	0	0	0	1	0	0	0	0												
Housing Enhancement for Special Populations	1501	216	307	213	170	76	1512	22	29	17	36												
Mental Health Programs																							
Mental health Services for Families/Children/Adolescents	185	25	14	20	8	39	7	8	6	0	52												
Mental Health Services Special Needs Population	133	25	30	23	98	3	50	4	10	5	57												
Mental Health Services for Adults	49	43	95	5	2	5	4	37	10	37	8												
Harm Reduction Programs																							
Harm Reduction Services	3111	137	262	759	52	89	824	3	19	21	180												

Source: Document 080: Ryan White Title I Program Monitoring Report to the New York City Department of Health, March 2000-February 2001 (February 2002), Medical and Health Research Association of New York.

⁷ Total counts are not included because data are for unduplicated clients; therefore a single person can be counted as a client as many times as she or he receives a service from different organizations reporting client data.

Resource Inventory

A. Introduction

In previous sections, the needs assessment describes the populations most affected by the HIV/AIDS epidemic in New York City. Also identified are different specific populations and their service needs.

The purpose of this section is to provide an inventory of the HIV/AIDS-related primary care and support services that are available in New York City.

B. CARE Act Service Sites

In a recent collaboration between Columbia University and MHRA, the CHAIN cohort's service utilization was geographically displayed for presentation to the Planning Council (document 019). In order to accomplish this, researchers assembled a very large amount of CARE Act administrative contract data from Title I, Title II, Title III, Title IV, and Special Projects of National Significance in New York City. In order to achieve a high level of accuracy in locating where CARE Act services were actually delivered to clients, the researchers identified the physical site of the service and included outstationed providers and sub-contractors in their database.

Figure 9 presents five New York City maps generated from this database. The maps display the distribution and location of five broad categories of HIV/AIDS service sites by zip code area. These categories are health, case management, drug treatment, housing, professional mental health, and supportive mental health. (Note that the scale is different for each map.)

The maps show the following about CARE Act services in New York City:

- Higher concentration of health services exist in lower and northern Manhattan and Bronx.
- Case management and drug treatment are more widely dispersed than health services.
- Housing services (not including HUD/HOPWA funded services) are more concentrated in Manhattan and south and central Brooklyn.
- Few sites exist providing supportive mental health services.

With respect to the CHAIN cohort's service utilization, the project revealed:

- Little variation among boroughs regarding the client's current medical provider.
- Manhattan residents were least likely to report case managers.
- Very few Queens residents report professional or supportive mental health services.
- Staten Island had the highest proportion of drug treatment utilization.

C. Core HIV/AIDS Services

The City of New York has responded to the HIV/AIDS epidemic by providing care services, supportive services, prevention programs, and free counseling and testing for those with, or at risk of, HIV/AIDS.

- *CARE Act Title I.* Through the Planning Council, the MO/APC ensures that nearly \$120 million (2001) in annual Federal funding is allocated according to a public planning process that involves people from every community affected by HIV. The NYC Department of Health and its master contractor, MHRA, contract to dozens of community-based AIDS service organizations in order to provide outpatient medical and social services citywide.
- *Housing Opportunities for People with AIDS (HOPWA).* The MO/APC also oversees the distribution of \$48 million (2001) in annual Federal funding for housing and social services for people with HIV. The NYC Department of Housing, Preservation, and Development (HPD), the Human Resources Administration (HRA), the Department of Mental Health (DMH), and non-profit organizations are involved in providing these services.
- *HIV/AIDS Services Administration (HASA).* A component of the City's Human Resources Administration, HASA provides case management, access to benefits, housing, and other services to eligible New Yorkers with clinical HIV disease. Serving over 42,000 clients, HASA is the largest provider of social services to persons with HIV in the U.S.
- *Counseling and Testing.* DOH operates 22 sites, co-located with STD testing and treatment services to provide HIV counseling and testing. These sites offer free, anonymous, and confidential testing for HIV, as well as referral and partner notification services. The Health and Hospitals Corporation (HHC) also offers counseling and testing for people incarcerated in NYC Department of Corrections facilities.
- *Prevention and Education.* Through direct services, contracts with community-based organizations, and disbursements of funds from the Federal Centers for Disease Control and Prevention, DOH provides a wide range of prevention, education, and health promotion services to the City's at-risk communities. DOH also offers a wide range of HIV-related training and professional education programs, and it operates an HIV resource library. HHC also supports HIV

primary and secondary prevention services at all public hospitals and health clinics.

- *AIDS Surveillance and Research.* DOH's HIV/AIDS Surveillance Program tracks the course of the HIV epidemic in the City, generating information on HIV/AIDS cases. DOH's Office of AIDS Research conducts serosurveys and evaluations of NYC HIV programs.
- *Anti-Discrimination Protection.* The NYC Commission on Human Rights (CHR) enforces the City's Human Rights Law, which prohibits discrimination based on disability, including HIV status. CHR also operates the HIV Prison Project, which provides education, counseling, and continuity of care for inmates of New York City and State jails.

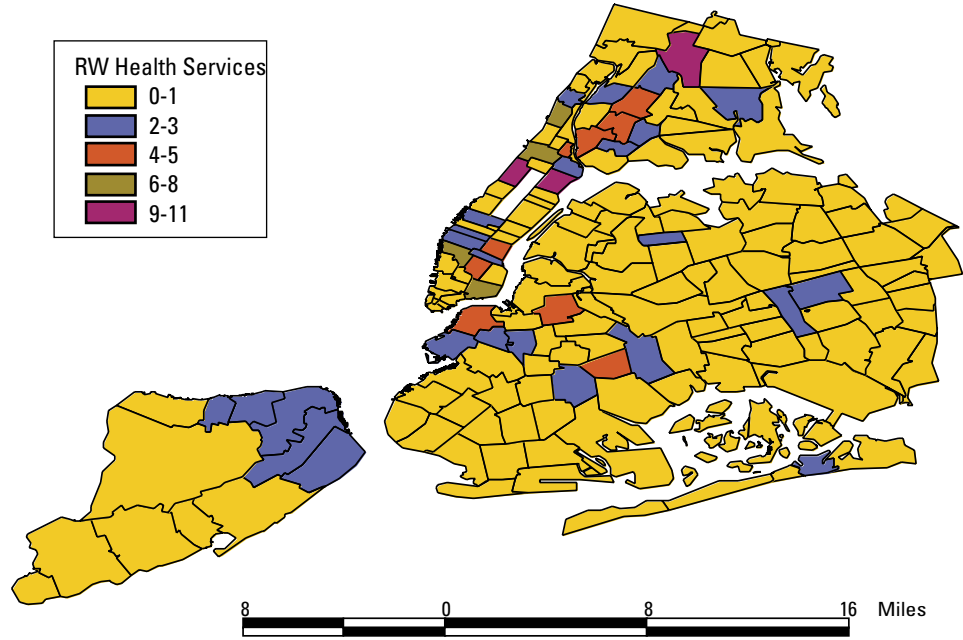
Table 10 is a guide to the types of Title I services in New York City and their distribution by borough among new clients. The reader can also see the total amount of funding for each of the sub-categories and the number of programs that are funded. Note the certain categories lack client data because they are recent programs, or because they are programs that do not directly serve clients. In addition, new client data by borough for several programs administered by the New York State AIDS Institute are not available.

D. Other Funding

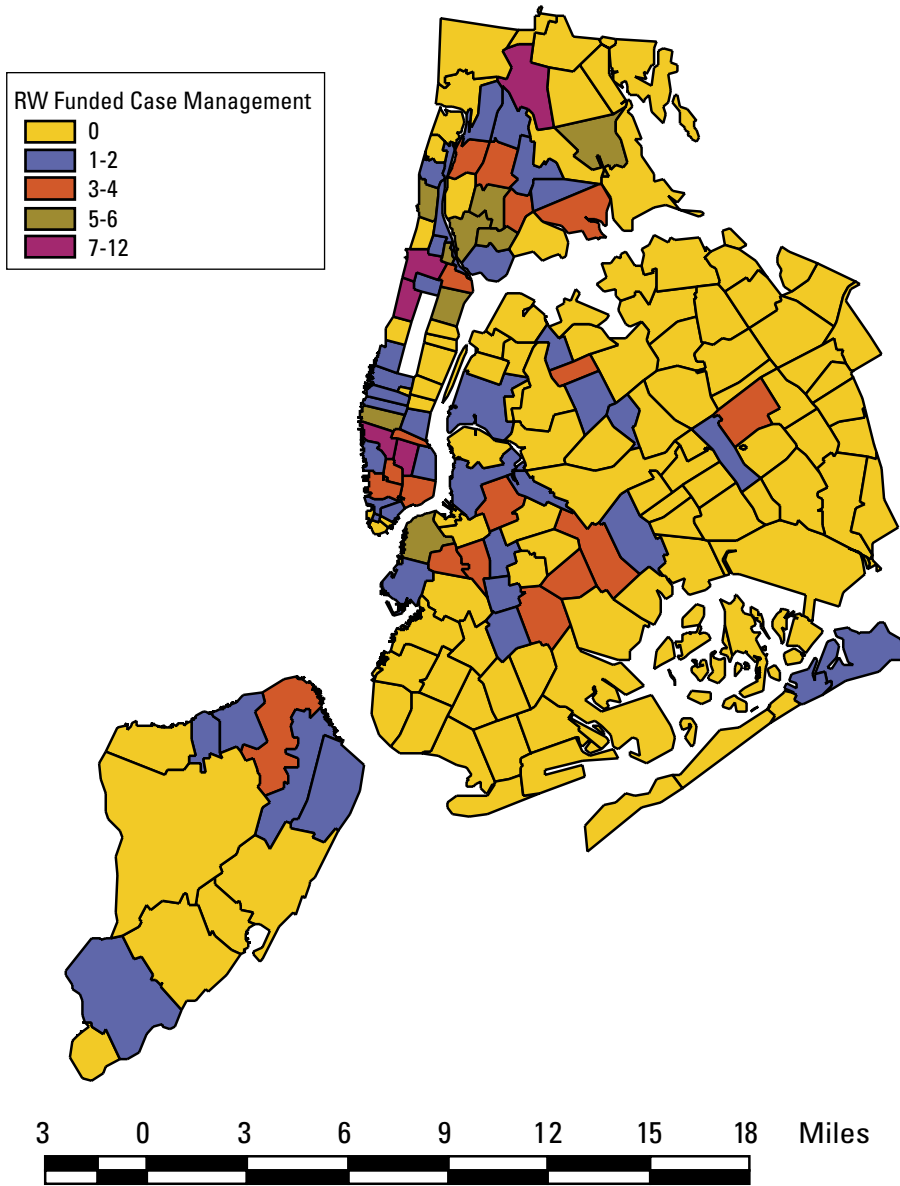
Table 11 provides an accounting of the level of Federal, State, and local funding for the major service categories compared to Title I funding for 1999. The other funding sources may include Title II, Title III, Title IV, HOPWA, other HUD, the CDC and substance abuse funding. The amounts are for the entire New York EMA.

Figure 9. CARE Act-Funded Service Sites: Health, Case Management, Drug Treatment, Housing, Professional Mental Health, and Supportive Mental Health.

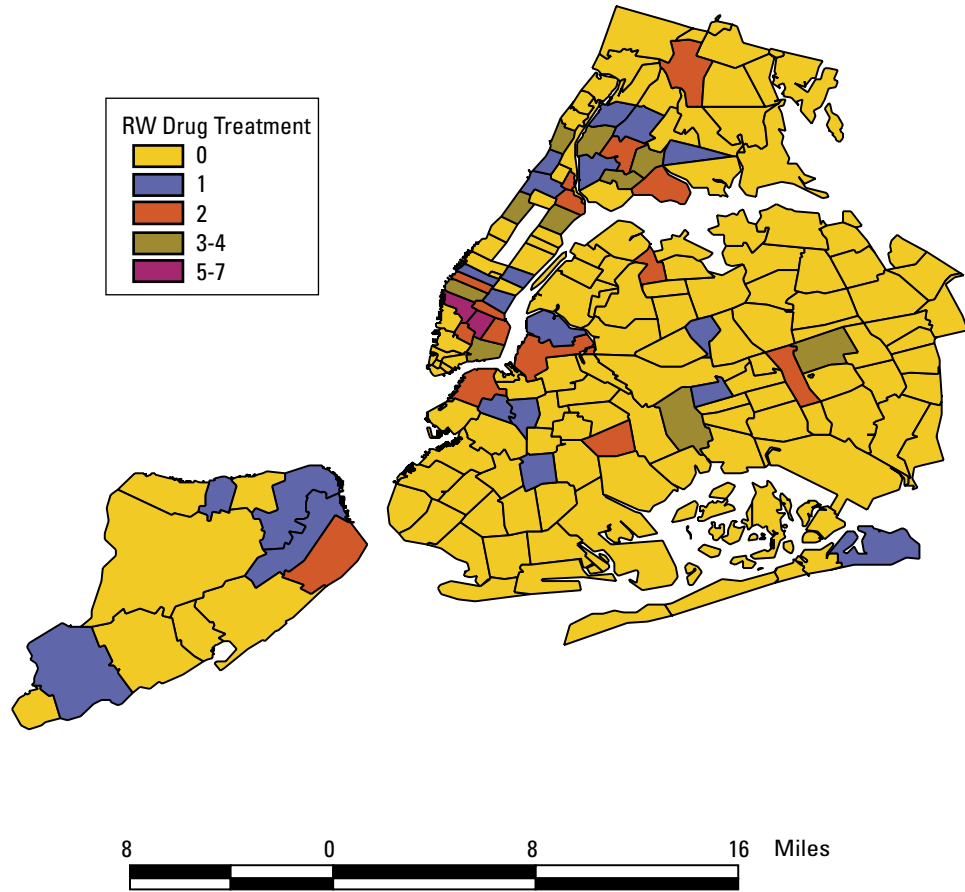
Health



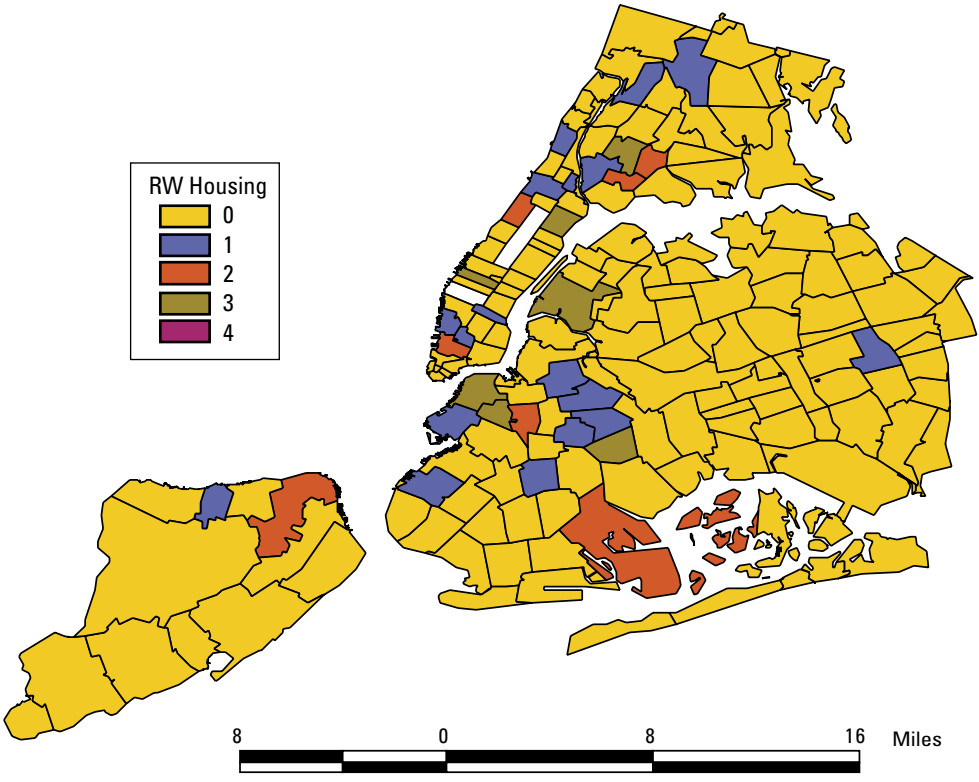
Case Management Sites



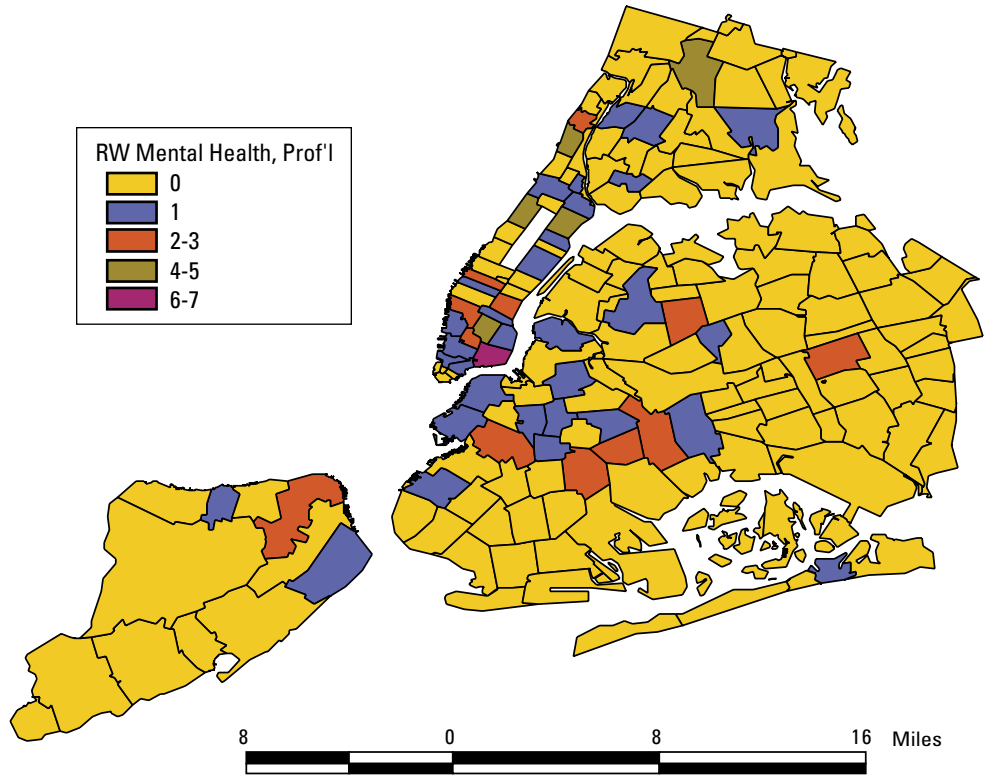
Drug Treatment



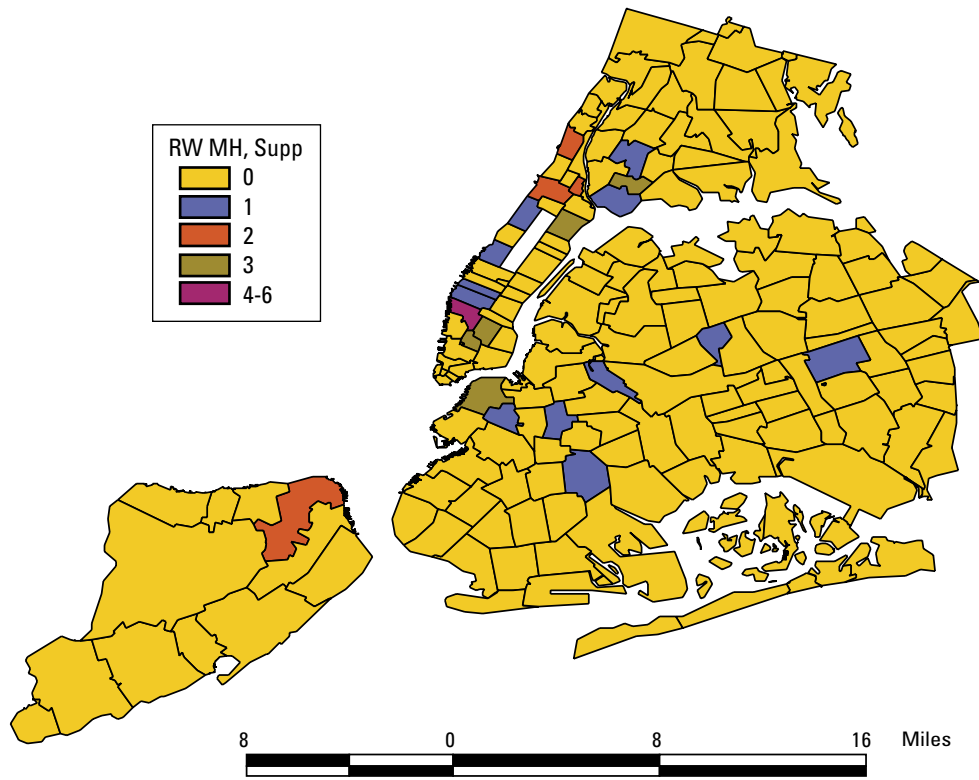
Housing



Professional Mental Health



Supportive Mental Health



Source: Document 019: CHAIN Update Report #42: A Geographic Display of the CHAIN Cohort's Service Utilization, December 2001, Columbia University and MHRA.

Table 10. Core HIV/AIDS Service Categories and New Clients⁸ by Borough, March 2000-February 2001

Service Categories	Total Funding	Total # of Title I Contracts/ Subcontracts & Programs	Percent of New Clients by Borough of Residence							Homeless Other Unknown	
			A	B	C	D	E	F	G		H
HEALTH CARE SERVICES PROGRAM CATEGORIES											
Reimbursement pools ⁹	\$16,671,000	1		20.2%	25.6%	33.5%	18.5%	2.2%			
Air Bridge Project ¹⁰	\$ 701,155	3		32.8%	7.0%	24.0%	18.8%	0			17.5%
Outpatient medical care	\$6,329,330	23		22.2%	33.2%	22.8%	11.5%	3.4%			7.0%
Home care	\$1,753,275	5		23.2%	26.9%	37.1%	5.4%	0			7.3%
Treatment education ¹¹	\$1,000,590	7		27.0%	3.4%	45.6%	18.6%	0			5.5%
Tuberculosis services	\$1,648,294	6		11.3%	16.3%	54.6%	2.1%	0			15.6%
Dental care	\$475,334	3		19.8%	43.7%	29.1%	4.3%	0.3%			2.8%
Adult day treatment	\$803,788	4		43.8%	2.0%	17.6%	30.7%	0			5.9%
Primary care development in community health centers and substance abuse centers ¹²	\$2,960,778	6		Data not available							
Service enhancements to substance abuse treatment programs, women and children's integrated HIV services, and treatment adherence demonstration projects ¹²	\$4,595,258	20		Data not available							
Treatment adherence support	\$90,013	2		Data not available							
Assessment teams in ER/harm reduction settings	\$33,825	1		Data not available							
Hepatitis C screening and treatment	\$125,194	2		Data not available							
Outstationed medical care teams in SROs	\$98,852	1		Data not available							

⁸ Percents reflect total data for unduplicated clients; therefore a single person can be counted as a client as many times as she or he receives a service from different organizations reporting client data. Data on new clients are not available for certain programs because data from New York State AIDS Institute programs are reported but not aggregated with other Title I contracts, because programs do not provide direct services to clients, or because contracts were awarded in the latter part of the year and not available.

⁹ These funds support three New York State AIDS Institute programs: AIDS Drug Assistance Program (ADAP), Outpatient Medical Care (ADAP+), and Home Care. New client data do not include new home care clients.

¹⁰ The Air Bridge Project provides medical, case management, and nutritional services to persons living with HIV/AIDS who migrate between New York and Puerto Rico.

¹¹ Includes programs that did not provide direct services to clients.

¹² These programs are administered by the New York State AIDS Institute through a single contract with MHRA.

Table 10. Core HIV/AIDS Service Categories and New Clients^a by Borough, March 2000-February 2001

Service Categories	Total Funding	Total # of Title I Contracts/ Subcontracts & Programs	Percent of New Clients by Borough of Residence								
			A	B	C	D	E	F	G	H	I
HOUSING PROGRAM CATEGORIES											
Housing placement assistance	\$554,250	2		39.4%	22.3%	22.9%	6.3%	0	9.2%		
Housing enhancements for special populations	\$3,637,478	1		13.2%	10.3%	12.4%	3.5%	0.4%	60.1%		
Technical assistance for HIV/AIDS housing providers	\$288,452	2		Data not available							
MENTAL HEALTH PROGRAM CATEGORIES											
Mental health services for families, children, and adolescents	\$2,638,101	11		40.3%	11.0%	25.1%	17.6%	.01%	5.9%		
Mental health services for special populations	\$2,362,695	6		20.7%	14.0%	45.0%	3.1%	0.3%	17.1%		
Mental health services for adults	\$1,407,537	7		12.3%	30.6%	28.1%	16.7%	0.6%	11.7%		
Geographically targeted mental health services	\$108,258	2		Data not available							
HARM REDUCTION PROGRAM CATEGORIES											
Harm reduction/ recovery readiness/ relapse prevention for active and recovering AOD users	\$8,877,427	25		35.8%	14.0%	32.1%	7.3%	1.8%	9.0%		
Rikers Island transitional services	\$981,117	6		8.1%	6.3%	7.0%	55.9%	0.5%	22.2%		
Family-centered harm reduction/recovery readiness/relapse prevention for active and recovering AOD users	\$2,593,520	9		38.5%	24.6%	15.0%	15.8%	.01%	6.0%		
SOCIAL SERVICE PROGRAM CATEGORIES											
Case management	\$6,401,134	24		32.7%	20.1%	22.2%	11.9%	4.3%	8.6%		
Food and nutrition	\$5,821,524	11		39.7%	14.4%	22.1%	4.6%	5.2%	14.0%		
Client advocacy	\$4,605,720	16		18.4%	36.0%	14.2%	12.5%	2.8%	16.0%		
Promoting access to early intervention	\$1,043,015	4		41.6%	26.7%	13.7%	9.1%	0.1%	8.7%		
Transportation	\$787,950	1		44.9%	14.3%	18.9%	20.0%	0	1.9%		
Supportive counseling	\$1,771,817	6		27.0%	31.7%	23.1%	11.7%	1.5%	3.7%		
Buddy/respite services	\$559,556	4		30.4%	29.7%	23.1%	11.7%	1.5%	3.7%		
Custody planning and transitional support	\$1,447,154	7		39.5%	32.3%	6.4%	14.1%	1.8%	5.9%		

Table 10. Core HIV/AIDS Service Categories and New Clients¹⁹ by Borough, March 2000-February 2001

Service Categories	Total Funding	Total # of Title I Contracts/ Subcontracts & Programs	Percent of New Clients by Borough of Residence								
			A	B	C	D	E	F	G	H	I
INFRASTRUCTURE PROGRAM CATEGORIES											
Building and sustaining organizational capacity	\$2,489,522	13									
Enhancing staff capacity to serve people living with HIV/AIDS	\$260,828	2									
MINORITY HIV/AIDS INITIATIVE¹⁹ PROGRAM CATEGORIES											
Access to care	\$987,354	8									
Maintenance in care	\$789,879	7									
Treatment education	\$360,436	7									
Treatment adherence consortia	\$151,333	3									

Source: Document 080: Ryan White Title I Program Monitoring Report to the New York City Department of Health, March 2000-February 2001 (February 2002), Medical and Health Research Association of New York. Columns B and C: Table IVA (p53) and Table IV-A1 (p 57) for health programs (p53), Table IV-C for housing programs (p86), Table IV-D (p97) for mental health programs, Table IV-E (p111) for harm reduction programs, Table IV-F (p127) for social service programs, Table IV-G (p146) for infrastructure programs, Table IV-H (p159) for CBC/MHAI programs.

¹⁹These programs were originally referred to as “CBC,” or “Congressional Black Caucus” programs.

**Table 11. Title I Funding in the Context of Other Public Funding
by Service Area for 2000 (In Millions)**

Service Category	CARE Act Title I	Other Federal Funds	State Funds	Local Funds	Total Funds¹⁴
A	B	C	D	E	F
Home/community-based support services	\$40.2	\$155.5	\$142.2	\$149.2	\$487.0
Ambulatory/outpatient medical care	\$24.5	\$355.4	\$186.2	\$166.1	\$732.1
AIDS Drug Assistance Program	\$10.1	\$77.1	\$35.4	0	\$122.5
Other outpatient/ community-based health care services	\$27.3	\$152.2	\$116.6	\$30.3	\$326.4
Inpatient medical care services	0	\$327.1	\$163.6	\$163.6	\$654.2
Grantee administrative costs, planning council support, program support, and other activities	\$17.3	0	0	0	\$17.3
Total funds	\$119.3	\$1,067.2	\$643.9	\$509.2	\$2,339.6

Source: New York City Department of Health

¹⁴Amounts rounded.

Profile of Provider Capacity and Capability

A. Introduction

This section examines the capacity and capability of providers of HIV/AIDS services in New York City, including: provider technical assistance (TA) needs, barriers to receipt of services and organizational strategies for overcoming barriers, and organizational outcomes.

B. Organizational Capability and Capacity

In 2001, an initiative sponsored by the Planning Council began to collect data on technical assistance service needs in New York City.¹⁵ The objectives of this project are:

- to identify and evaluate the scope and effectiveness of TA currently provided to AIDS services organizations (ASOs) in the New York City EMA, and
- to assess future TA needs, with a particular focus on neighborhoods of high HIV prevalence.

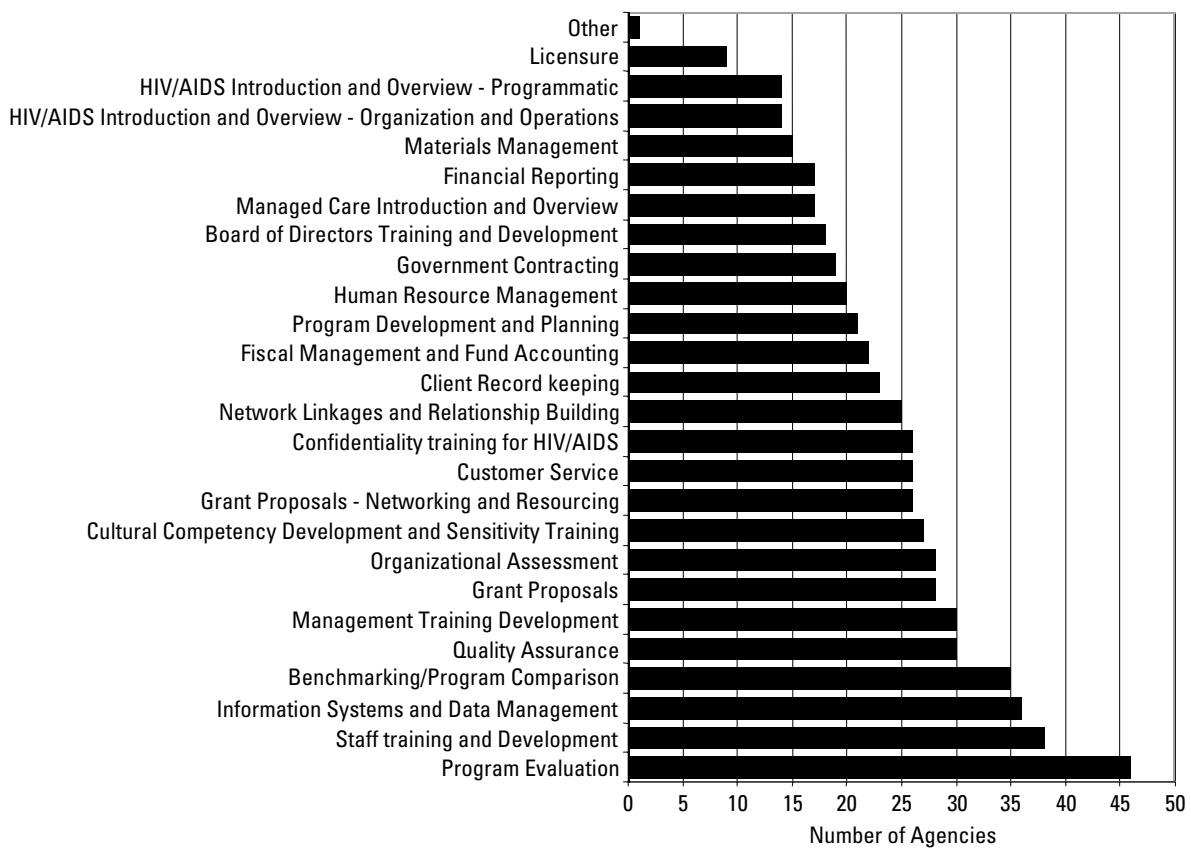
Early findings from this project include:

- *Distribution of TA Services:* Minority neighborhoods in Brooklyn and Manhattan are currently receiving the largest share of the TA services. Qualitative data, however, indicate that these services have a less than desirable impact due to a lack of culturally appropriate TA service providers. The future success of this program will rely on the ability to attract and retain providers who are proficient in minority healthcare and social models.

¹⁵ A report entitled, "Ryan White Title I Technical Assistance Services Impact Study and Needs Assessment" is being prepared by the project researcher, the Center for Health Policy Studies. The report will be issued later in 2002. The study gathered data from 71 HIV/AIDS agencies within the New York EMA.

- *Typology of TA Services:* The majority of the current Title I services use classroom-type training (academic models) to present topics of general interest. Much of the data gathered suggests that this model of training has limited impact and that agencies desire more individualized approaches. Many of the agencies felt that the current level of training offered through Title I providers was below their organizational ability.
- *Future TA Needs.* As shown in Figure 10, data indicate that future TA will need to focus in the areas of program evaluation, staff training and development, information systems and data management, benchmarking and program comparison, quality assurance, and management training.

Figure 10. Future Technical Assistance Service Needs by Service Category



Source: Document 049

- *Barriers to Receiving TA Services.* The majority of the agencies indicated that the reason they had not requested and/or received TA was due to financial causes (i.e., funding was not available). Although Title I TA services are made available at no cost, providers of TA indicated that they are operating at capacity

and have turned some agencies away. The agencies also indicated that, due to prior experiences with Title I TA services, they are instead purchasing at their own expense similar services through private consultants.

- *Best Practices in TA.* A majority of the agencies indicated that they had received TA services through HRSA and CDC. These agencies were most frequently cited for having “best practice” models for delivering TA services. Key factors in the delivery of best practice services were indicated as including one-on-one evaluation and individualized service development, the use of mentors, low turnover in consultant staff, detailed goals and goal tracking, and program evaluation. Most of these attributes were cited as being absent in the current methods of delivering Title I funded TA services.

C. Barriers and Strategies to Address Them

Barriers are defined as impediments to accessing care, and include:

- Structural barriers – service availability, how services are organized, and issues such as child-care and transportation.
- Financial barriers – insurance coverage, reimbursement levels, and the extent of public support.
- Personal barriers – acceptability, cultural and language appropriateness, attitudes, and education/income related issues.

Data suggest that barriers to care for people living with HIV in New York City have lowered over the years. According to CHAIN’s “Unconnected Revisited” report in May 1999 (document 047:4&5), efforts to eliminate barriers have succeeded in decreasing the numbers of persons unconnected to HIV/AIDS care and treatment. Successes in increasing the access of all sub-populations to combination therapies and in the high levels of access to primary care for New Yorkers with HIV also reflect a lowering of barriers.

Despite progress, Table 12 lists, by special populations, barriers to receipt of services that still exist in New York City – as well as potential strategies to overcoming barriers. Care must be taken in interpreting Table 12 findings in that many of the barriers listed are based on qualitative information. (See Section 8 below, for more information on the limitations of qualitative needs assessment data.) Note also that no data were available for this table on infants and children. Finally, readers are reminded that barriers are closely associated with targeted service needs and disparities, which are presented above in Table 7.

While some barriers are unique to a given population, many affect multiple populations. Barriers mentioned in Table 12 that affect more than one population – and potential strategies for addressing them – include:

- Clients with multiple service needs -- especially women with children, the homeless, AODs, MICAs, immigrants/ undocumented, recent detainees/releasees, and the unconnected -- each encounter problems associated with gaining access to and negotiating the requirements of multiple agencies and funding sources. The availability of high intensity case management, the co-location of services, the availability of low-threshold services, and the strengthening of inter-agency referral arrangements can all help mitigate these problems and provide more integrated care for multiple-need clients. For clients who are less ambulatory, transportation services that are not restricted to one trip per day or limited to use for primary care visits, can also lower the barriers associated with multiple needs.
- Homelessness, which affects all populations, is a serious problem in and of itself. Lack of housing particularly impacts the most vulnerable, and presents a unique combination of barriers that prevent clients from accessing a range of other services. This includes staying in services once accessed and utilizing services effectively. For example, without refrigeration and a place to prepare meals, new therapies are challenging for the homeless to manage. Thus, decreasing rates of homelessness not only directly solves one of the most persistent problems faced by people living with HIV/AIDS in New York City, but also helps remedy other service barriers encountered by the homeless. Since many of the homeless have multiple service needs, the solutions outlined above also apply to this group.
- A lack of cultural sensitivity and stigmatization on the part of providers is identified in relationship to a number of different populations, including: youth, MSM, substance users, and those with mental illness. Suggested strategies for addressing problems of insensitivity focus on provider training, the use of peer outreach workers, and the inclusion of clients in program planning and implementation, such as Community Advisory Boards (CABs).
- A lack of client knowledge (ranging from a lack of understanding about how to access the health care system, to misinformation regarding actual side effects from combination therapies) is noted across a number of populations. Strategies for addressing a lack of knowledge vary based on population affected and range from using the schools, in the case of youth, to a focus on peer educators for substance users.

Table 13 reports cost and outcome effectiveness data drawn from the documents listed in Table 2. Intermediate outcomes are those that reflect client linkages with or use of services. Long-term outcomes focus on such issues as improved health status. Client satisfaction and service quality measures are also included in this category. While there are gaps in terms of outcomes that apply to specific populations, in the areas of general health there are a number of outcomes, most of which are positive. Note that outcome and cost data were not available for several specific populations: youth, inmates/releasees, and immigrants.

Table 12: Barriers to Care by Population and Strategies to Overcome Barriers/Retain in Care

Specific Population	Barriers	Strategies to Overcome Barrier/Retain in Care
A	B	C
Youth	<p>11:105. According to the 2002 Title I Application, the homeless population includes an estimated 20,000 homeless adolescents, many of whom engage in sex for survival and who encounter barriers unique to the youth population combined with those unique to the homeless population.</p> <p>57:No page number. According to the PPG Adolescent workgroup, obstacles that youth face in seeking appropriate care include a lack of money, minimal knowledge of the health care system, the prevailing notion that they need their parents’ consent to obtain health care, fear of disclosing their status, and a health care system that is not aware of or sensitive to the special needs of youth.</p>	<p>86:4. According to McClain & Associates (2/2002), the requirement of most Title I funded services that eligible clients have documentation of their HIV-positive status can be a barrier to service receipt for youth. Providers pursue a variety of strategies that will allow them to provide services to such clients without delay, including using non-Title I funds until the client’s status can be documented.</p> <p>57:not numbered. In Adolescent Speak Out Sessions (1998), sponsored by the Prevention Planning Group, young participants suggested the following strategies for addressing the HIV-related needs of youth: take your message to places where youth congregate (e.g., parties, clubs, the beach, youth hang outs, etc.); focus on sexual behavior, not orientation; utilize the media to deliver prevention messages; do not “talk down” to youth; involve youth in program development; provide incentives and rewards for participation (free food, safe sex kits); realize that youth relate best to peers – use peer educators when possible – “stories” from the lives of peers are especially compelling; involve schools more in HIV education; increase education around testing and dispel myths about HIV reporting; and keep messages positive and hopeful in tone.</p>

Table 12 *continued*

*Barriers to Care
by Population
and Strategies
to Overcome
Barriers/Retain
in Care*

AOD

Specific Population	Barriers	Strategies to Overcome Barrier/Retain in Care
A	B	C
AOD	<p>32:9. Per a CHAIN overview report (2000), participants are less satisfied with AOD providers than with any other categories of social service or medical providers. This can be a barrier to seeking AOD services.</p> <p>95:5. According to a 3/2000 NYAM study, AODs often experience long waits for short medical visits. Waits are difficult for active users, especially during withdrawal. Users often feel stigmatized by providers who lack experience with and feel uncomfortable providing care to this population.</p> <p>95:4&5. A 3/2000 NYAM study found AODs less likely to receive consistent HIV medical care than non-users because of the need to address daily survival issues and a perception (often correct) that they do not receive quality health care.</p> <p>18:26. Per CHAIN (12/2001), barriers related to stigma, discrimination, ignorance, and poor treatment by medical providers are particularly problematic for AODs.</p> <p>11:91. The Title I Year 2002 application points out that those actively using substances are at risk of losing public assistance or Medicaid. Many programs bar active users altogether. On the other extreme, some programs are oblivious to drug use and therefore fail to make appropriate referrals.</p>	<p>65:2. According to a Housing Workgroup Year 12 template (undated), in order to overcome barriers AODs need housing that is low threshold, safe, and that provides on-site services.</p> <p>92:8. Per an NYAM study (undated), programs offering needle exchange as a core service tend to exchange a greater number of syringes, while programs offering syringe exchange as an auxiliary service provide a model of how such programs might be integrated into agencies with a broader mission.</p> <p>18:26. Per CHAIN (12/2001), barriers encountered by substance users are likely to be ameliorated "low threshold" services. This approach does not demand total abstinence as a condition of service, but focuses on rendering services in as flexible and user-friendly manner as possible.</p> <p>18:26. Per CHAIN (12/2001), "low threshold" services are particularly recommended as a way to improve utilization of testing services by high-user AODs.</p> <p>95:33 to 35. A 3/2000 NYAM study recommends the following to break down barriers of AOD users accessing medical care services: increase patients knowledge and empowerment; train providers on addiction and its effects, pain medication, and providing care that is appropriate for this population; target and train</p>

Specific Population	Barriers	Strategies to Overcome Barrier/Retain in Care
A	B	C
AOD (continued)		<p>specific ER staff to deal with this population; increase outreach staff with a harm reduction focus; increase commitment to quality correctional health care.</p> <p>95:33 to 35. A 3/2000 NYAM study makes the following recommendations specifically targeted at primary care offices: have flexible hours and drop-in slots; provide incentives and rewards; create referral linkages with services that address AODs most pressing needs; provide on-site case managers.</p>
MSM	<p>57:not numbered. According to the PPG 2000 Prevention Plan, Volume IV, HIV+ Native American (NA) (the majority of whom were MSM) who were surveyed listed the following barriers to receipt of services: the small number of infected in the NA community make this a low priority for providers and policy makers, most providers are not culturally sensitive to the needs of NA, 9% stated that they lacked financial resources.</p> <p>57:not numbered. According to the PPG 2000 Prevention Plan, Volume IV, a study of Asian/Pacific Islander MSM failed to find significant differences in access to services based on English fluency, immigration status or employment status. In qualitative interviews, however, racism and stigma related to homophobia were frequently mentioned as barriers.</p>	<p>57:not numbered. According to the PPG 2000 Prevention Plan, Volume IV, overcoming barriers encountered by HIV+ American Indians (AI) include: the need for coalition and network building among agencies that provide AI services, cultural sensitivity training for providers, and development of a resource directory specifically targeted at AI.</p>

Table 12 *continued*

Barriers to Care by Population and Strategies to Overcome Barriers/Retain in Care

AOD

MSM

Table 12 *continued*

*Barriers to Care
by Population
and Strategies
to Overcome
Barriers/Retain
in Care*

Women

Specific Population	Barriers	Strategies to Overcome Barrier/Retain in Care
A	B	C
Women	<p>33:2. Per CHAIN (6/2000), single mothers reported a lack of child-care as a barrier to accessing medical services.</p> <p>52:3. Funding is needed for childcare at HIV program sites.</p> <p>44:10 through 24. Per CHAIN (5/1999), female participants are more likely than males to list fear of side effects as an impediment to taking HAART.</p> <p>33:3. Per CHAIN (6/2000), nearly twice as many female participants encounter barriers to accessing social services (38%) as compared to barriers to accessing medical services (20%).</p> <p>33:3. Per CHAIN (6/2000), women living in a group setting (which usually implies provision of on-site services), or being integrated into the care system (due to one's eligibility for TANF benefits) increases the probability of receiving appropriate medical care.</p> <p>33:24. Per CHAIN (6/2000), the majority (60%) of women who live alone and who have at least one barrier to medical services reported facing transportation problems when attempting to get to their medical appointments.</p> <p>33:24-25. Per CHAIN (6/2000), the relationship between reporting at least one type of access to social services barrier and family type is statistically significant. Cost of services is a barrier only among women who live alone, and child care is a barrier only among single mothers. The lack of service-related information is a widespread</p>	<p>11:91. Per the Title I 2002 application, more women than men qualify for Medicaid. While 27% of people living with HIV/AIDS are female, 50% of Medicaid recipients filing HIV/AIDS claims are women.</p> <p>76:3. Ideally, congregate meal sites would provide child care services, as well as other types of social services on location.</p>

Specific Population	Barriers	Strategies to Overcome Barrier/Retain in Care
A	B	C
Women (continued)	<p>barrier among all family types as are delays in seeing a social service provider.</p> <p>92:12. According to NYAM (undated), most residential drug treatment programs are not able to provide services to women with children, creating a barrier for those who have no child care alternatives.</p> <p>76:3. Several congregate meal sites report low participation of women and children in their programs (only at around 25%) due to the lack of child care at meal sites.</p>	
Inmates/ releasees	<p>60:1 through 4. A Y11 AOD Workgroup template states that large numbers of HIV+ inmates are discharged without receiving counseling, testing, AOD services, or community service referral and placements partially because of the time of day (the middle of the night) and location in which they are released.</p>	<p>60:1 through 4. A Y11 AOD Workgroup template prioritized funding to provide a 24-hour Access, Referral and Drop-in Center for HIV+ prison releasees near the release point for Riker’s Island detainees and prisoners to overcome these barriers.</p>
MICAs	<p>11:91. Per the Title I 2002 application, for MICAs it can be particularly challenging to access the multiple services they need (i.e., alcohol/drug treatment and mental health services).</p> <p>32:14. Per a CHAIN overview report (2000), many clients receiving low mental health scores on a standardized test do not perceive the need for mental health services.</p> <p>65:2. According to a Housing Workgroup Y12 template (undated), subpopulations most affected by a lack of housing include mentally ill/substance abusers. Since public housing requires a period of drug-</p>	<p>11:104. Per the Title I 2002 application, treatment for mental illness may improve access to health care – individuals with low mental health scores who receive mental health services are twice as likely to enter into and be retained in appropriate medical care as those who do not receive services.</p> <p>11:103. Per the Title I Year 2002 application, for MICAs requiring multiple services (i.e., alcohol/drug treatment and mental health services), service co-location can greatly increase access.</p>

Table 12 *continued*

Barriers to Care by Population and Strategies to Overcome Barriers/Retain in Care

Women

Inmates/ releasees

MICAs

Table 12 *continued*
*Barriers to Care
 by Population
 and Strategies
 to Overcome
 Barriers/Retain
 in Care*

MICAs

*Immigrants/
 undocumented*

Specific Population	Barriers	Strategies to Overcome Barrier/Retain in Care
A	B	C
MICAs (continued)	free time prior to housing, AODs may be particularly impacted.	68:5. According to a Y12 Housing template (7/2001), many PLWHA living in enhanced supportive housing programs are MICAs. "Housing enhancements" are defined as a bundle of services including, but not limited to: mental health services, clinical social work, bereavement counseling, substance abuse counseling, primary health care under Article 28, transportation, parenting skills, activities of daily living training, independent living skills, harm reduction services, therapeutic recreation services, and supportive services. All of these services, individually and in combination, help to break down barriers for the dually diagnosed.
Immigrants/ undocumented	<p>90:23. According to Sociomedical Resource Associates (12/2001), a lack of health insurance among many immigrants – especially the undocumented – is a major barrier to receipt of care. Low literacy decreases access to prevention and care information. Fear of disclosure is a barrier to access. Many immigrants do not learn of their HIV status until they are diagnosed with AIDS; many immigrant women learn of their status when they are pregnant.</p> <p>11:105. According to the 2002 Title I Application, among legal immigrants, 40% are uninsured – among undocumented persons, the proportion is far higher. Many immigrants who entered the US in 1996 or after face a five-year waiting period before they can qualify for federal benefits. Undocumented persons, with</p>	<p>90:23. According to Sociomedical Resource Associates (12/2001), social networks in some immigrant communities (especially the more well established, such as the Dominican) at least partially mitigate against the lack of insurance coverage among the undocumented.</p> <p>90:No page cited. According to a 12/2001 study by Sociomedical Resource Associates, Hispanics are extremely diverse. Given this diversity, the authors suggest that possibly the best way to ensure cultural relevance in service planning and delivery is to include individuals from the affected community in service implementation.</p> <p>11:105. According to the 2002 Title I Application, for those ineligible for Medicaid, including the</p>

Specific Population	Barriers	Strategies to Overcome Barrier/Retain in Care
A	B	C
Immigrants/ undocumented (continued)	exceptions for emergencies and for pregnant women, are barred from receiving such services altogether.	undocumented, Title I funds a range of programs including ADAP and ADAP Plus. These individuals also have access to certain Title II-and New York State-funded primary and ancillary care services. 86:4. According to McClain & Associates (2/2002), the requirement of most Title I funded services that eligible clients have HIV+ documentation may be a barrier to service receipt with the undocumented particularly impacted. Providers pursue a variety of strategies that will allow them to provide services to such clients without delay, including using non-Title I funds to deliver services while the client's status can be documented.
Homeless	11:109. According to the 2002 Title I Application, the lack of a permanent residence poses a substantial impediment to obtaining federal benefits. Although Medicaid provides the bulk of primary care health care for the homeless, not all are eligible. 11:109. According to the 2002 Title I Application, without food, a place to prepare meals, and refrigeration, new therapies may be hard for the homeless to manage.	11:109. According to the 2002 Title I Application, Title I programs fund a range of programs that provide services to the homeless who would otherwise, because of a lack of insurance coverage, not be able to access such services. This includes ADAP and ADAP Plus, as well as an array of harm reduction, mental health and other social services, as well as housing services.

Table 12 *continued*

Barriers to Care by Population and Strategies to Overcome Barriers/Retain in Care

Immigrants/ undocumented

Homeless

Table 12 *continued*
*Barriers to Care
 by Population
 and Strategies
 to Overcome
 Barriers/Retain
 in Care*

Unconnected

Specific Population	Barriers	Strategies to Overcome Barrier/Retain in Care
A	B	C
Unconnected	<p>60:1 through 4. This Y11 AOD Workgroup template points out that the unconnected have often had negative encounters with the health care system, which contribute to their lack of engagement with the system.</p> <p>57:not numbered. According to the PPG 2000 Prevention Plan, Volume IV, barriers that can prevent transgender individuals from receiving HIV services include: the lack of agency policies regarding the treatment of transgender clients, “transphobia” or the lack of informed and/or compassionate providers, and a lack of sustainable funding for transgender clients.</p>	<p>57:not numbered. PPG sponsored focus groups in all 5 boroughs examined the most effective way to reach the unconnected. Suggested methods included: (1) street outreach, (2) peer education, and (3) harm reduction/needle exchanges.</p> <p>57:not numbered. According to the PPG 2000 Prevention Plan, Volume IV, barriers that can prevent transgender individuals from receiving HIV services can be partially overcome by: expanding transgender support groups, the provision of transgender sensitivity and safe-sex training for providers, and the availability of literature targeted at the transgender population and its issues.</p> <p>47:27 & 28. Based on the “Unconnected Revisited” report, CHAIN (5/1999) recommended the following to overcome barriers: (1) Continue to expand high-intensity outreach efforts. (2) Outreach is necessary not only for entry into care, but maintenance. (3) Continue to develop and refine very low threshold “service readiness” programs (based on harm reduction models). The provision of services that address basic survival needs may be necessary intermediate steps in terms of engaging this population. (4) The unconnected need to receive better education on the benefit of early HIV intervention. Providers need to better understand prevailing myths and fears about HIV treatment. (5) There is much need to education HIV providers about the unconnected -- who they are and the barriers that exist to their seeking care (including bureaucratic</p>

Specific Population	Barriers	Strategies to Overcome Barrier/Retain in Care
A	B	C
<p>Unconnected (continued)</p>		<p>rules and a sense of stigma). (6) Agencies should be encouraged to enlist the help of those they already serve who have contact with the unconnected. (7) Agencies that serve this population need to work together to identify best practices and create linkages that make for a more effective network of care.</p> <p>87:2. In its draft policy on early intervention services (12/2001), the MO/APC stated that outpatient medical care and case management service providers will be required to maintain formal, written referral relationships with agencies at key points of entry into the health care system, including HIV testing and counseling centers, STD clinics, emergency rooms, homeless shelters, detoxification programs, adult/juvenile detention centers, federally qualified health care centers, and Ryan White Title I Access to Care programs.</p> <p>78:1 through 4. Per a Y12 Social Services Workgroup template funding for additional early intervention services was prioritized as necessary to help link the unconnected with care. Funded programs will be required to provide HIV counseling and testing on-site or have a direct link to counseling and testing services.</p> <p>60:1 through 4. Per a Y11 AOD Workgroup template funding to provide 13 harm reduction escort and follow-up workers was prioritized. Workers will accompany clients to and from appointments and other activities that should help engage and maintain them in services.</p>

Table 12 *continued*
Barriers to Care by Population and Strategies to Overcome Barriers/Retain in Care

Unconnected

Table 12 *continued*

*Barriers to Care
by Population
and Strategies
to Overcome
Barriers/Retain
in Care*

*General HIV/AIDS
Population–Health*

Specific Population	Barriers	Strategies to Overcome Barrier/Retain in Care
A	B	C
General HIV/AIDS Population – Health	<p>41:3. Per CHAIN (5/2000), barriers to receipt of HAART include: lack of continuous comprehensive health care (most important barrier) and lack of insurance.</p> <p>89:ES. In a 1998 Montefiore study reasons for delays in accessing dental care included: feeling uncomfortable with dentists (71%); procrastination (69%); minimizing the problem (69%); long waits at the office (57%); not knowing how to identify a dentist (50%); a perception that Medicaid status results in poor treatment (70%); a feeling that their dentist does not understand HIV (20%); feeling stigmatized (15%). The most common barrier reported to accessing dental care was a lack of dental insurance (percentage not noted).</p> <p>44:12 through 24. Per CHAIN (5/1999), the following are impediments to receipt of HAART: side effects and fear of side effects (49%), a belief that the medication is unnecessary (39%), non-beneficial (21%) or still experimental (19%).</p>	<p>41:3. Per CHAIN (5/2000), strong patient-provider relationships are associated with HAART adherence.</p> <p>89:ES. In a 1998 Montefiore study survey respondents reported that they were more likely to access dental services if such services were integrated with their primary medical care. They also reported that proximity to providers, help identifying dentists, and help making appointments would facilitate access to dental care. The report recommended the use of mobile dental vans, oral health education, oral health case management, and the addition of outreach workers as ways to enhance client access to dental care.</p>

Specific Population	Barriers	Strategies to Overcome Barrier/Retain in Care
A	B	C
<p>General HIV/AIDS Population–Social Services</p>	<p>86:4. According to McClain & Associates (2/2002), travel and meals are typically provided for peer counselors, but stipends tend to be small or non-existent due to agency concerns that peers might lose public benefits if paid.</p> <p>42:6. Per CHAIN (5/1999), fear of losing benefits inhibits PLWHA from seeking employment. There is a reality-base to this fear as 17% who have returned to work have lost all or part of their benefits.</p> <p>42:9. Per CHAIN (5/1999), only 14% of participants face no impediments in returning to work. Barriers include: 40% have less than a HS education, 40% have physical limitations, 20% are disabled because of substance abuse problems, >30% have low mental health functioning.</p>	<p>93:2 & 3. Per a Policy Roundtable hosted by MTS, flexible work incentives and transitional benefits that allow for realities of HIV disease are necessary to encourage a return to work. Relatedly, educational programs are needed that target both consumers and providers. A significant public education campaign that would address attitudes related to hiring PLWHA is also important. Lastly, the expansion of alliances and coalitions of organizations interested in this topic should be encouraged.</p> <p>42:6. Per CHAIN (5/1999), SSI and SSDI should continue while PLWHA reenter the workforce.</p> <p>74:1. Per a Y11 Social Services Workgroup template (7/2001), providing funding for new transportation services (at least one car and driver per borough) will help improve clients' ability to access needed health and social services.</p>

Table 12 *continued*

Barriers to Care by Population and Strategies to Overcome Barriers/Retain in Care

General HIV/AIDS Population–Social Services

Sources: Document numbers are indicated for each entry.

Table 13: Cost and Outcome Effectiveness

Population	Intermediate Outcomes	Long-Term Outcomes
A	B	C
Children		123:No page number. According to a recent AP/Albany Times Union article (2/12/02), the rate of vertical HIV transmission from mother to child in NY state has decreased "dramatically" -- from 25% to 3.5% -- since the implementation of a 1997 law requiring infant HIV testing and maternal notification.
AOD	92:8. Per an NYAM study (undated), programs offering needle exchange as a core service tend to exchange a greater number of syringes, while programs offering syringe exchange as an auxiliary service provide a model of how such programs might be integrated into agencies with a broader mission. In 1999 NYC needle exchange programs served an estimated 30,000 to 40,000 individuals.	32:9. Per a CHAIN overview report (2000), participants are less satisfied with AOD providers than with all other categories of social service and medical providers. 92:10, Per a NYAM study (undated), NYC needle exchange programs have been shown to reduce HIV transmission. They have also been related to marked decreases in needle sharing and modest decreases in the frequency of injection.
MSM		43:13. Per CHAIN (5/1999), men tend to report better health functioning than women
Women	11:91. Per the Title I Year 2002 Application, more women than men qualify for Medicaid. While 27% of people living with HIV/AIDS are female, 50% of Medicaid recipients filing HIV/AIDS claims were women. 33:3. Per CHAIN (6/2000), nearly 2/3 (63%) of female CHAIN study participants across all family types reported receiving appropriate medical care. In addition, 79% of women living in group quarters and 71% of single mothers are receiving appropriate medical care, despite	43:13. Per CHAIN (5/1999), men tend to report better health functioning than women.

Population	Intermediate Outcomes	Long-Term Outcomes
A	B	C
<p>Women (continued)</p>	<p>challenges such as poverty and the need for substance abuse treatment services.</p> <p>33:14. Per CHAIN (6/2000), women who live with a male partner and children are the least likely to report having been diagnosed with one or more opportunistic infections in the six months prior to the interview (21%), while women who live with other adults and children are the most likely to report an opportunistic infection in the preceding six months (56%).¹</p>	
<p>MICAs</p>	<p>30:3. Per CHAIN (6/2000), persons with low mental health functioning are more likely to experience a loss of entitlement benefits between CHAIN interviews.</p> <p>30:16. Per CHAIN (6/2000), among those with low mental health scores, approximately 53% of all participants have received mental health services. Approximately 1/3 of these received services from a mental health professional; 1/3 from a support group, and 1/4 from a social worker or case manager.</p> <p>30:24 through 26. Per CHAIN (6/2000), African American participants are least likely of all racial groups to receive mental health services from a mental health professional.</p>	

Table 13 *continued*

Cost and Outcome Effectiveness

Women

MICAs

Table 13 *continued**Cost and Outcome Effectiveness**Homeless*

Population	Intermediate Outcomes	Long-Term Outcomes
A	B	C
Homeless	<p>28:2 through 11. Per CHAIN (5/2000), housing services improve a person's chances of securing stable, adequate housing and reduce the risk of losing housing. Rental subsidy is the strongest predictor of securing and maintaining housing. Supportive services (case management, mental health and/or drug treatment) are also important in helping to achieve housing stability.</p> <p>23:6 & 7. Per CHAIN (7/2001), 13% of participants who are not stably housed have no medical care (compared to 3% for the stably housed) and 32% have inadequate medical care (compared to 23% for the stably housed). 32% of the unstably housed have experienced an interruption in medical care, compared to 25% for the stably housed. 10% of the unstably housed lack health insurance, compared to 3% for the stably housed. 32% of the unstably housed were delayed for three months or more in seeking HIV care compared to 20% who were stably housed.</p> <p>37:3. Per CHAIN (5/2000), people with housing needs who get assistance are almost four times more likely to enter into medical care than those who do not get assistance. If the assistance is housing-focused case management this figure leaps to 10 times.</p> <p>44: 10 through 24. Per CHAIN (5/1999), the stably housed are almost five times more likely than others to report continuous use of HAART.</p>	<p>109:2 through 8. Per CHAIN (11/2001), participants who are homeless are more likely to report that their current health status is only fair or poor (43%) than is true of the stably housed (29%). Controlling for other factors, participants who are homeless report higher viral loads (29%) than those who are stably housed (24%). Participants who are homeless are more likely to report poor physical functioning (58%) than those who are stably housed (50%). They are also more likely to have very low mental health functioning (32%) than those who are stably housed (27%).</p>

Population	Intermediate Outcomes	Long-Term Outcomes
A	B	C
<p>General HIV/AIDS Population – Health Related Outcomes</p>	<p>35:13. Per CHAIN (4/2000), in 1995, the use of combination therapy never exceeded 10% of participants. During the first half of 1996, use jumped to 33% and increased to 50% during the second half of that year. By the second half of 1997, 70% of participants were on combination therapy.</p> <p>41:3. Per CHAIN (5/1999), access to HAART is no longer limited by broad categories of social disadvantage (e.g., race/ethnicity, education, poverty).</p> <p>21:2. Per CHAIN (10/2001), appropriate medical care is significantly associated with the increased likelihood of being on antiretroviral therapy, but only tenuously related to the likelihood of being adherent to HIV medications.</p> <p>26:10 & 11. Per CHAIN (4/2001), participants report a high level of experience with combination therapies (82%). Over two interview periods, 21% reported the adherent use of combination therapies and 54% show less consistent adherence. 7% reported having stopped combination therapy use.</p> <p>21:2. Per CHAIN (10/2001), housing services, drug treatment, professional mental health care, and case management were all significantly associated with increased reporting of appropriate medical care. All of these but drug treatment were also associated with increased use of antiretroviral therapy. However, none of these services showed a positive impact on increasing adherence to HIV medications.</p> <p>32:9. Per a CHAIN overview report (2000), 97% of participants have a</p>	<p>35:13. Per CHAIN (4/2000), combination therapies and PCP prophylaxis for individuals with CD4 counts below 200 have been associated with a significant decrease in mortality risk.</p> <p>35:13. Per CHAIN (4/2000), as of the first half of 1999 there was no evidence of an upturn in mortality rates based on the failure of combination therapy.</p> <p>24:3. Per CHAIN (10/2001), there are no differences in health outcomes attributable to the type of provider rendering care (i.e., private physicians, HHC providers, neighborhood/ drug treatment centers, voluntary hospitals).</p> <p>43:13. Per CHAIN (5/1999), there has been an overall trend toward improved health for CHAIN participants, particularly among younger individuals and those who report they are completely adherent to ARV therapies. Men tend to report better health functioning than women and individuals who believe in their ability to manage their own health often report better health behaviors and outcomes.</p> <p>20:19. Per CHAIN (9/2001), participants have experienced a significant decrease in the use of the emergency room and the length of inpatient stays (although not the number of stays) over time.</p> <p>20:19. Per CHAIN (9/2001), trends in racial/ethnic disparities in health outcomes seen in other diseases are not evident amongst the HIV+ population. Part of the reason for this, according to CHAIN, is that the typical white</p>

Table 13 *continued*

Cost and Outcome Effectiveness

General HIV/AIDS Population–Health Related Outcomes

Table 13 *continued**Cost and Outcome Effectiveness**General Population–Health Related Outcomes*

Population	Intermediate Outcomes	Long-Term Outcomes
A	B	C
General Population – Health Related Outcomes (continued)	<p>provider and 94% had an outpatient visit within the last six months. As of 1999 there were no significant differences based on race. Almost all participants have health insurance (82% have Medicaid).</p> <p>43:2 through 8. Per CHAIN (5/1999), there has been a decline in participants who lack health insurance from 8% to 2%.</p> <p>89:ES. In a 1998 Montefiore study, about half of the survey respondents did not receive a regular dental check up in the prior year and half required emergency dental care. Overall, 74% saw a dentist in the prior year.</p> <p>25:6&7. Per CHAIN (11/2001), comparing Ryan White CARE Act funded services to non-CARE Act funded services, the following was found: those receiving RWCA funded primary care were 60-70% more likely to report appropriate medical care, were 40-50% more likely to report being on HAART, and were 50% more likely to receive care that met HIV care guidelines; those receiving RWCA funded case management or advocacy services were 80-90% more likely to report appropriate medical care and 70% more likely to be on ARV.</p> <p>43:12. Per CHAIN (5/1999), the proportion of participants who state that their regular medical provider has met all three criteria for appropriate HIV care has increased over time from 49% at the start of CHAIN to 63% in 1998.</p> <p>50:16. Per CHAIN (4/1998), Overall, those in managed care are not at a disadvantage with respect to</p>	<p>CHAIN participant is at a more advanced stage of HIV disease than is true of either African American or Latino participants.</p> <p>56:No page number cited. According to the High Need Index II, there were no statistically significant differences in Medicaid expenditures per person across the five NYC boroughs.</p> <p>32:9. Per a CHAIN overview report (2000), participants are more satisfied with their medical providers (70-80% report very high satisfaction) than with their social services providers. Dissatisfaction has more to do with the patient-provider relationships than the technical practice of medicine.</p> <p>89:1. In a 1998 Montefiore study 70% of survey respondents had oral pain at the time of the survey and about 2/3rds rated their oral health as poor.</p> <p>89:ES. In a 1998 Montefiore study, 82% of survey respondents stated that they would recommend their dentist to others.</p> <p>50:2. Per CHAIN (4/1998), those in managed care spend fewer days in the hospital, are slightly less likely to use the ER, and have more frequent outpatient visits than those not in managed care.</p> <p>20:19. Per CHAIN (9/2001), participants have experienced a sharp drop in mortality and significant improvements in physiological measures of disease progression (i.e., an increase in T-cells, a decrease in</p>

Population	Intermediate Outcomes	Long-Term Outcomes
A	B	C
General Population – Health Related Outcomes (continued)	medical services received and do not have less access to HAART. 41:3. Per CHAIN (5/1999), 75% of participants were using HAART by 1998. Higher usage was found in those with low CD4 counts or an AIDS diagnosis.	viral load, and a decrease in opportunistic infections). 43:2 through 8. Per CHAIN (5/1999), regarding perceived health functioning, fewer participants report “poor” overall health and fewer report that their health has declined in the last six months compared to earlier in the epidemic. Neither the comprehensiveness of care nor provider continuity are associated with improved health care indicators. 37:3, Per CHAIN (5/2000), in the aggregate, all the co-morbidities examined in this study (TB, STDs, substance use, very poor mental health, and unstable housing) showed a general decline over time. 20:19. Per CHAIN (9/2001), participants have experienced a significant reduction in the extent to which emotional feelings have impaired their abilities to interact on a normal basis with family and friends.
General Population – Social Services Related Outcomes	32:16. Per a CHAIN overview report (2000), participants who receive case management were more than twice as likely to maintain medical care that meets clinical standards than those who do not have a case manager. The unconnected are nine times more likely to enter medical care if they have a case manager.	

Table 13 *continued*

Cost and Outcome Effectiveness

General Population–Health Related Outcomes

General Population–Social Services Related Outcomes

Sources: Document numbers are indicated for each entry.

Assessment of Service Gaps and Unmet Need

A. Introduction

An important step in service planning is analyzing to the degree possible the relationship between the services being provided, the services being sought by clients, and the services actually needed by the HIV/AIDS population as a whole. This section of the needs assessment addresses this relationship. It presents information on service gaps and unmet needs for persons in care, and additional information regarding those unconnected to care, including persons who are aware of their HIV-positive status but not in care.

B. Assessment of Service Gaps and Unmet Need

Table 14 presents potential gaps in 25 different Title I-eligible services as identified by people with HIV disease (primarily available through the CHAIN project), and by researchers, providers, and others. These two sources – people with HIV disease and researchers/others – are shown separately so that the input of people with HIV can be as direct as possible into the needs assessment and planning process. In addition, the table presents any special population issues associated with the particular service category that were found in the list of source found in Table 2.

Note that data were not available for several service categories: hospice, rehabilitation services, buddy/companion services, psychosocial support services, day or respite care, and translation/interpretation. As with the other data gaps in the needs assessment table, this does not necessarily indicate that these services have no unmet needs or special population issues. Rather, it is a function of the contents of the source documents used to develop the tables. This, in turn, is determined by the survey questions posed to people with HIV disease, and by the topics pursued by researchers.

¹⁶ A quantitative study of AOD services, funded through the Mayor's Office, will be released in spring 2002.

In total, Table 14 presents data that suggests the following:

- Health care services, and the financial coverage that allows access to those services, are generally available to people with HIV/AIDS living in New York City, even the most disenfranchised groups.
- Numerous qualitative and quantitative sources cited in Table 14 confirm that homelessness and unstable housing are the most persistent and ongoing gaps facing the New York City HIV/AIDS care system. Individuals from vulnerable populations, such as those with AOD and mental health problems, women with children, immigrants and the undocumented, and recent prison releasees, all encounter even more daunting housing problems than is true of the general population. As discussed more extensively in Section 6 of the needs assessment, homelessness not only directly impacts a substantial number of people living with HIV/AIDS but acts as a barrier to access for other critical services, such as the receipt of anti-retroviral therapy.
- A potential gap in the areas of both mental health and AOD services warrants further exploration. As discussed more extensively in Section 8 of the needs assessment, it is not always easy to differentiate between the clinical need for a service and clients' willingness to use that service even if it is available. For example, a CHAIN overview report (32:14) found that only about half of the CHAIN participants who had AOD problems received treatment in the past six months, and the majority of these individuals stated that treatment is important to them. However, (11:103), the Office of Alcoholism and Substance Abuse Services (OASAS) estimates that among persons with alcohol or substance abuse problems, only 20-35% will actually enter into treatment if available. A similar phenomenon exists among those with mental health issues. CHAIN found that many individuals suffering from serious mental illness (as measured by a standardized tool) were not even aware that they had a problem (32:14). To better determine the actual gap between service availability and client willingness to use such services, more study (particularly research that is quantitative in nature) is recommended .
- A potential gap in the area of dental services also deserves further study. Although in a 1998 Montefiore survey (89:ES) about half of the respondents did not receive dental care in the prior 18 months, in many instances it was access barriers (not knowing where to find a dentist; fear of dental work) that prevented individuals from connecting to care, not a lack of available dental care. As with mental health and AOD services, further quantitative research may be needed before reaching a final conclusion that a service gap exists in this area.

Table 15 provides another way of understanding unmet needs. This table presents service needs of persons in care and unconnected to care by special population. No data were available for these specific populations: infants and children, men who have sex with men, and immigrants/undocumented. Again, their absence from this table is only meaningful with respect to the contents of the database from which it was derived.

C. Assessment of Needs of HIV+ Aware Not In Care

Clinical care and medications play a significant role in preventing illness and death among people with HIV. Early entry into the continuum of care is recommended for persons with HIV infection, well before symptoms emerge. Yet the extent to which persons who are aware of their HIV-positive status and not in care is unknown.

Therefore, HIV health and social services planning must consider the needs of persons aware of their status who are not in care. Table 16 examines issues related to the broader category of unconnected to care, with a special focus on those who are aware of their HIV-positive status, but not in care. The table also includes information on persons who are unaware of their HIV status. These groups are combined because much of the currently available literature fails to differentiate between them. The table examines the special needs of this population, services available to them, potential gaps in services, and barriers to receipt of services.

Table 14: Assessment of Service Gaps and Unmet Need

Service Category	Service Gaps and Unmet Need		Special Population Issues
	Identified by People with HIV Disease	Identified by Researchers, Providers, and Others	
A	B	C	D
Ambulatory/outpatient medical care	<p>32:13. Per a CHAIN overview report (2000), consumer health care complaints tend to focus on the desire for providers who are more caring and understanding, and whom they can trust.</p> <p>50:2. Per CHAIN (4/1998), those in managed care spend fewer days in the hospital, are slightly less likely to use the ER, and have more frequent outpatient visits than those not in managed care.</p> <p>32:16. Per a CHAIN overview report (2000), participants who receive case management were more than twice as likely to maintain medical care that meets clinical standards than those who do not have a case manager.</p> <p>50:2. Per CHAIN (4/1998), at least as of the time of writing, managed care was not an important factor in the delivery of HIV+ medical services in NYC. As of 1997, only 12% of the HIV population was enrolled in managed care. Those who were enrolled tended to be white, MSM, high income and asymptomatic, and in better general health. The coverage of managed care plans was generally on a par with fee-for-service, with those in managed care having slightly better access to combination therapy than those in fee-for-service.</p>	<p>95:5. According to a 3/2000 NYAM study, AODs often experience long waits for short medical visits. Waits are difficult for active users, especially during withdrawal. Users often feel stigmatized by providers who lack experience with and feel uncomfortable providing care to this population.</p>	<p>65:2. According to a Housing Workgroup Y12 template (undated), 46% of those in unstable housing lack adequate health care.</p> <p>41:3. Per CHAIN (5/1999), HAART usage is lowest among those: in (or at risk of) unstable housing; who have low mental functioning; are responsible for the care of three or more dependent children; or who regularly use crack/cocaine.</p> <p>90:5. Per Sociomedical Resource Associates, ((12/2001) in a needs assessment of Latino immigrants in NYC/Tri-county, country of origin, current community of residence, gender roles, health beliefs, and immigration status all related to health services utilization.</p> <p>109:2 through 8. Per CHAIN (11/2001), participants who are homeless are more likely to report that their current health status is only fair or poor (43% than is true of the stably housed (27%). Controlling for other factors, participants who are homeless report higher viral loads (29%) than those who are stably housed (24%).</p>

Table 14: Assessment of Service Gaps and Unmet Need

Service Category	Service Gaps and Unmet Need		Special Population Issues
	Identified by People with HIV Disease	Identified by Researchers, Providers, and Others	
A	B	C	D
Ambulatory/outpatient medical care (continued)			<p>65:2. According to a Housing Workgroup Y12 template (undated), housing is "the most urgent need among the services required to support access to and maintenance in healthcare."</p> <p>108:47. According to the Title I 2002 Request for Proposals, African Americans with HIV have particularly high rates of delayed entry into HIV primary care.</p> <p>24:3. Per CHAIN (10/2001), participants with private doctors are more likely to be white, MSM, more educated, less impoverished, and sicker than is true of those who do not use private doctors. Participants who use an HHC provider are more likely to be black, over 50, and below the poverty level. Participants who receive care at neighborhood/ drug treatment centers tend to be younger, less educated and healthier. Participants who receive care at voluntary hospitals are likely to be more balanced demographically.</p>

Table 14: Assessment of Service Gaps and Unmet Need

Service Category	Service Gaps and Unmet Need		Special Population Issues
	Identified by People with HIV Disease	Identified by Researchers, Providers, and Others	
A	B	C	D
Medications	<p>41:3. Per CHAIN (5/2000), barriers to receipt of HAART include: lack of continuous comprehensive health care (most important barrier) and lack of insurance.</p> <p>44:12 through 24. Per CHAIN (5/1999), the following are impediments to receipt of HAART: side effects and fear of side effects (49%), a belief that the medication is unnecessary (39%), non-beneficial (21%) or still experimental (19%). 90% of participants who are on HAART obtained information from their current medical provider and 92% felt that they received a clear explanation of the drugs and their side effects.</p>		<p>44: 10 through 24. Per CHAIN (undated), one factor associated with never taking HAART is unstable housing. African Americans are more likely to fall into this category than others.</p> <p>38:11. Per CHAIN (6/2000), in 1998 90% of white participants had initiated HAART, while 2/3 of blacks had done so.</p>
Health insurance	<p>43:2 through 8. Per CHAIN (5/1999), there has been a decline in participants who lack health insurance from 8% to 2%.</p>		
Home health care		<p>9:27. According to the DASIS quarterly performance report (Dec 2000), very few DASIS cases receive home care services.</p>	

Table 14: Assessment of Service Gaps and Unmet Need

Service Category	Service Gaps and Unmet Need		Special Population Issues
	Identified by People with HIV Disease	Identified by Researchers, Providers, and Others	
A	B	C	D
Oral health care	<p>89:ES. In a 1998 Montefiore study survey respondents reported that they were more likely to access dental services if such services were integrated with their primary medical care. They also reported that proximity to providers, help identifying dentists, and help making appointments would facilitate access to dental care. The report recommended the use of mobile dental vans, oral health education, oral health case management, and the addition of outreach workers as ways to enhance client access to dental care.</p> <p>89:ES. In a 1998 Montefiore study about half of the survey respondents did not receive a regular dental check up in the prior year and half required emergency dental care. Including emergency care, overall, 74% saw a dentist in the prior year.</p> <p>89:ES. In a 1998 Montefiore study reasons for delays in accessing dental care included: feeling uncomfortable with dentists (71%); procrastination (69%); minimizing the problem (69%); long waits at the office (57%); not knowing how to identify a dentist (50%); a perception that Medicaid</p>	<p>89:ES. A 1998 Montefiore study found that Medicaid and ADAP participants are able to access comprehensive dental care, however those covered for even a portion of their dental expenses from these or other programs are not eligible to be funded by any Title I program.</p> <p>89:ES. In a 1998 Montefiore study 64% of survey respondents reported a serious delay or total inability to access needed dental care.</p> <p>108:44. According to the Title I 2002 RFP, few patients living with HIV receive comprehensive oral health care through a continuous relationship with an oral health care provider.</p> <p>89:ES. A 1998 Montefiore study reported that Title I funds for HIV dental care decreased in three fiscal years, 1996-1999, while requirements for the provision of dental care increased. This resulted in a reduction in the scope and breadth of dental care available, a decline in the number of training fellowship slots, and a reduction in the number of clients and services delivered. At the time of the study, less than 20% of NYS dentists routinely participated in the Medicaid</p>	<p>89:ES. A 1998 Montefiore study found that PLHA view dental care as a top priority. 70% of those surveyed gave the maximum rating score to the importance of oral health.</p>

Table 14: Assessment of Service Gaps and Unmet Need

Service Category	Service Gaps and Unmet Need		Special Population Issues
	Identified by People with HIV Disease	Identified by Researchers, Providers, and Others	
A	B	C	D
Oral health care (continued)	status results in poor treatment (70%); a feeling that their dentist does not understand HIV (20%); feeling stigmatized (15%). The most common barrier reported to accessing dental care was a lack of dental insurance (percentage not noted).	program, although an expected increase in Medicaid rates was postulated to improve this situation. Specific dental utilization data were not available, according to the authors. 89:ES. A 1998 Montefiore study of Title I dental services recommended the development of an ongoing dental needs assessment to better understand and describe the needs of those not eligible for ADAP, Medicaid, or Dental Reimbursement services. Also proposed was a Y12 pilot project funding one licensed dental program within an integrated HIV care center, standing clinic or hospital-based clinic. Note that this was proposed, but is contingent on FY2002 funding levels.	30:12 through 16. Per CHAIN (6/2000), the rates of mental health problems among PLWHA are much higher than is true of the general population. 20-25% of those PLWHA in care and 80% of those outside of care have a multiple diagnosis. 80% of those currently using drugs had mental health scores in the very low range at least once during their participation in CHAIN; 38% had very low scores at three or more interviews. Very low mental
Mental health services	32:14. Per a CHAIN overview report (2000), almost 50% of those having emotional or psychological problems (based on standardized test scores) do not receive mental health services. 32:14. Per a CHAIN overview report (2000), many clients receiving low mental health scores on a standardized test do not perceive the need for mental health services.	73:4. According to a 7/2001 Y12 Mental Health Workgroup template, their priority to fund co-located mental health treatment programs with primary care sites is designed to improve the availability and accessibility of professional mental health services. 73-LS-3. Per a July 2001 Mental Health Workgroup template (citing a May, 2001 CHAIN study), at least 40% of the original	

Table 14: Assessment of Service Gaps and Unmet Need

Service Category	Service Gaps and Unmet Need		Special Population Issues
	Identified by People with HIV Disease	Identified by Researchers, Providers, and Others	
A	B	C	D
Mental health services (continued)	30:24 through 26. Per CHAIN (6/2000), persons with low mental health functioning are more likely to experience a loss of entitlement benefits between CHAIN interviews, perhaps due to missed appointments and/or failure to maintain proper income documentation.	cohort has experienced clinically relevant mental health symptoms.	health scores are highly correlated with substance use in PLWHA. 30:24 through 26. Per CHAIN (6/2000), African American participants are least likely of all racial groups to receive mental health services from a mental health professional.
Nutritional counseling		76:1 through 3. Per a Social Services Workgroup Y11 template, nutrition counseling needs to be integrated with the provision of food service.	
Substance abuse services	32:14. Per a CHAIN overview report (2000), only about half of the participants who have had AOD problems in the prior six months received treatment. Yet the majority of AOD users state that treatment is important to them.	92:5&6. The need for syringe exchange continues to vastly outstrip current capacity. Estimates based on 1998 data suggest that programs reach only 15-20% of the city's IDUs and that only 2% of need would be met if the ideal of one syringe per injection were followed (i.e., IDUs are using the same syringe for themselves multiple times). Syringe exchange programs (SEPs) are missing in 11 of the highest need neighborhoods in NYC. Even in neighborhoods which have a SEP, only about 28% of IDUs are enrolled in the program.	60:1 through 6. According to a 6/2000 AOD Workgroup template, in 1997 a total of 5,474 individuals were tested for HIV upon entrance into the NYC Correctional System. Of these 7% of men and 19% of women tested positive. This highlights the need for drug treatment, HIV education, and HIV services in prison.
		92:12. According to an undated NYAM study, traditional approaches to drug	

Table 14: Assessment of Service Gaps and Unmet Need

Service Category	Service Gaps and Unmet Need		Special Population Issues
	Identified by People with HIV Disease	Identified by Researchers, Providers, and Others	
A	B	C	D
Substance abuse services (continued)		<p>treatment (methadone maintenance and abstinence-based programs) are not sufficiently available to meet the needs of NYC drug users. The Office of Alcoholism and Substance Abuse Services (OASAS) estimates that such programs statewide can offer treatment to only 42,000 of the state's estimated 550,000 substance abusers, 200,000 of whom are in NYC. Some 30,000 of these treatment slots are in methadone maintenance programs that address only heroin addiction, despite the fact that the majority of city drug users are addicted to cocaine or some combination of drugs. Most residential treatment programs are not able to provide services to women with children, compounding the treatment shortfall.</p> <p>60:1 through 4. This Y11 AOD Workgroup template prioritizes funding to provide 13 harm reduction escorts and follow-up workers to accompany clients to and from appointments and other activities that will help engage and maintain them in services.</p>	

Table 14: Assessment of Service Gaps and Unmet Need

Service Category	Service Gaps and Unmet Need		Special Population Issues
	Identified by People with HIV Disease	Identified by Researchers, Providers, and Others	
A	B	C	D
Treatment adherence services	<p>21:2. Per CHAIN (10/2001), there are several socio-demographic characteristics significantly associated with medication adherence – being male, over 50, having greater than a high school education, and being more recently diagnosed.</p> <p>41:3. Per CHAIN (5/2000), a strong patient-provider relationship is associated with HAART adherence.</p>		<p>44: 10 through 24. Per CHAIN (5/1999), whites are 30% more likely than blacks to report continuous use of HAART.</p> <p>43:13. Per CHAIN (5/1999), there has been an overall trend toward improved health for CHAIN participants, particularly among younger individuals and those who report they are completely adherent to ARV therapies. Men tend to report better health functioning than women and individuals who believe in their ability to manage their own health often report better health behaviors and outcomes.</p>
Child welfare services	<p>33:3. Per CHAIN (6/2000), single mothers reported a lack of child-care as a barrier to accessing medical services.</p> <p>52:1 through 10. 80% of PWA Advisory Group survey respondents stated that childcare was needed at HIV program sites.</p>	<p>75:1 through 3. Per a Y11 Social Services Workgroup template (7/2001), the need for advocacy services was identified as a funding priority. Advocacy services would address gaps related to: immigration, housing, permanency planning, custodial planning, and benefits.</p> <p>86:1 through 4. According to McClain & Associates (2/2002), Children who are not HIV+ receive permanency planning and other services after the loss of their parent. However, since Title I limits the funding of services for non-HIV infected individuals, agencies must find other funding sources to continue serving these children.</p>	

Table 14: Assessment of Service Gaps and Unmet Need

Service Category	Service Gaps and Unmet Need		Special Population Issues
	Identified by People with HIV Disease	Identified by Researchers, Providers, and Others	
A	B	C	D
Case management		9:2. According to the quarterly DASIS performance report for Oct-Dec 2000, most DASIS cases are in case management (72%), nearly 2/3 clients are males, about half (49%) are African Americans. A large majority (83%) receive some form of housing assistance.	
Client advocacy		75:1 through 3. Per a Y11 Social Services Workgroup template (7/2001), the need for advocacy services was identified as a funding priority. Advocacy services would address gaps related to immigration, housing, permanency planning, custodial planning, and benefits.	
Early intervention services	57:no page numbers. The Prevention Planning Group focus groups identified the top three prevention and early intervention methods as: street outreach, peer education, and harm reduction/needle exchange. 47:27 & 28. Based on their Unconnected Revisited report, CHAIN (5/1999) recommended: (1) Continue to expand high-intensity outreach efforts. (2) Outreach is necessary not only for entry into care, but maintenance. (3) Continue to develop and refine very low threshold "service	78:1 through 4. This Y12 Social Services Workgroup template prioritizes funding for additional early intervention services necessary to help link the unconnected with care. Funded programs will be required to provide HIV counseling and testing on-site or have a direct link to counseling and testing services. 87:2. In its draft policy on early intervention services (12/2001), the MO/APC stated that outpatient medical care and case management service providers will be required to	

Table 14: Assessment of Service Gaps and Unmet Need

Service Category	Service Gaps and Unmet Need		Special Population Issues
	Identified by People with HIV Disease	Identified by Researchers, Providers, and Others	
A	B	C	D
Early intervention services (continued)		<p>readiness" programs (based on harm reduction models). The provision of services that address basic survival needs may be necessary enabling/intermediate steps to engage this population. (4) The unconnected need to receive better educational services on the benefit of early HIV intervention. Providers need to better understand prevailing myths and fears about HIV treatment. (5) There is much need to educate HIV providers about the unconnected -- who they are and the barriers that exist to their seeking care (including bureaucratic rules and a sense of stigma). (6) Agencies need to be encouraged to enlist the help of those they already serve who have contact with the unconnected. (7) Agencies that serve this population need to work together to identify best practices and create linkages that make for a more effective network of care.</p> <p>78:1 through 4. Per a Y12 Social Services Workgroup template funding for additional early intervention services was prioritized as necessary to help link the unconnected with care. Funded programs will be required to provide HIV counseling</p>	<p>maintain formal, written referral relationships with agencies at key points of entry into the health care system, including HIV testing and counseling center STD clinics, emergency rooms, homeless shelters, detoxification programs, adult/juvenile detention centers, federally qualified health care centers, and Ryan White Title I Access to Care programs.</p>

Table 14: Assessment of Service Gaps and Unmet Need

Service Category	Service Gaps and Unmet Need		Special Population Issues
	Identified by People with HIV Disease	Identified by Researchers, Providers, and Others	
A	B	C	D
Early intervention services (continued)		<p>and testing on-site or have a direct link to counseling and testing services.</p> <p>60:1 through 4. Per a Y11 AOD Workgroup template funding to provide 13 harm reduction escort and follow-up workers was prioritized. Workers will accompany clients to and from appointments and other activities that should help engage and maintain them in services.</p>	
Emergency financial assistance		<p>67:10. According to a Housing Workgroup Y 12 template, 10% of NYC PLWA are not immediately eligible for DASIS housing assistance. The need exists for emergency rental assistance for this group. The highest priority should be for: the homeless, those in immediate risk of homelessness, and those who are spending >75% of their income on rent.</p>	
Food bank/home delivered meals/nutritional supplements		<p>76:1 through 3. Per a Y11 Social Services Workgroup template (7/2001), there is a need for additional food services for PLWHA. The Workgroup prioritized funding the enhancement of existing congregate food programs and pantry programs.</p>	

Table 14: Assessment of Service Gaps and Unmet Need

Service Category	Service Gaps and Unmet Need		Special Population Issues
	Identified by People with HIV Disease	Identified by Researchers, Providers, and Others	
	A	B	C
Health education/ risk reduction	57: not numbered. Youth-focused Prevention Planning Group (2000), based on feedback from focus groups composed of young people, urge providers to use peer education whenever possible and to provide youth with education on risk reduction, as well as on the how to get tested and the legal issues associated with disclosure.	57: no page numbers. The Prevention Planning Group focus groups identified the top three prevention and early intervention methods as: street outreach, peer education, and harm reduction/needle exchange. 47:27 & 28. Per CHAIN's "Unconnected Revisited" report, (5/1999) the unconnected need to receive better educational services on the benefit of early HIV intervention. Providers need to better understand prevailing myths and fears about HIV treatment.	92:5&6. 92:8. Per an NYAM study (undated), a condition of the waiver that allows needle exchange programs to operate requires such programs to provide not just clean needles, but HIV prevention education and supplies, and direct access or referrals to HIV counseling, testing, drug treatment and other services.
			D
			60:1 through 6. According to a 6/2000 AOD Workgroup template, high rates of sero-prevalence are found among men and women in NYC's correctional facilities, emphasizing the need for HIV related education and services in prison, including drug treatment.

Table 14: Assessment of Service Gaps and Unmet Need

Service Category	Service Gaps and Unmet Need		Special Population Issues
	Identified by People with HIV Disease	Identified by Researchers, Providers, and Others	
A	B	C	D
Housing assistance	<p>33:3. Per CHAIN (6/2000), 30% of women expressed a need for housing and housing services.</p> <p>52:1 through 10. 80% of PWA Advisory Group survey respondents reported that housing was their most pressing problem.</p> <p>111:1. Per a PWA Advisory Group Report (4/2001), 52% of consumer survey respondents listed housing (both permanent and transitional) as their most pressing need. This was the highest ranking need identified. Housing placement, rental assistance, and housing quality were also listed as priority services/issues.</p> <p>111:1. Per a PWA Advisory Group Report (4/2001), the PC ranked housing as its #1 priority for Year 12.</p> <p>32:15. Per a CHAIN overview report (2000), housing is the greatest unmet need among CHAIN participants. This has been true at every wave of the CHAIN study.</p>	<p>9:2. According to the quarterly DASIS performance report for Oct-Dec 2000, a large majority of clients (83%) receive some form of housing assistance.</p>	<p>65:2. According to a Housing Workgroup Y12 template (undated), the AOD population needs housing that is: low threshold, safe, that provides voluntary on-site services.</p> <p>65:1&2. According to a Y12 Housing Work Group template, 24% of PLWHA in NYC are homeless or in unstable housing at any one time. 46% of these individuals lack adequate health care.</p>

Table 14: Assessment of Service Gaps and Unmet Need

Service Category	Service Gaps and Unmet Need		Special Population Issues
	Identified by People with HIV Disease	Identified by Researchers, Providers, and Others	
A	B	C	D
Housing related services	33:3. Per CHAIN (6/2000), 30% of women expressed a need for housing and housing services.		28:2 through 11. Per CHAIN (5/2000), housing services improve a person's chances of securing stable, adequate housing and reduce the risk of losing housing. Rental subsidy is the strongest predictor of securing and maintaining housing. Supportive services (case management, mental health and/or drug treatment) are also important in helping to achieve housing stability.
Legal services		75:1 through 3. Per a Y11 Social Services Workgroup template (7/2001), the need for advocacy services was identified as a funding priority. Advocacy services would address gaps related to: immigration, housing, permanency planning, custodial planning, and benefits.	

Table 14: Assessment of Service Gaps and Unmet Need

Service Category	Service Gaps and Unmet Need		Special Population Issues
	Identified by People with HIV Disease	Identified by Researchers, Providers, and Others	
A	B	C	D
Outreach services		<p>57:no page numbers. The Prevention Planning Group focus groups identified the top three prevention and early intervention methods as: street outreach, peer education, and harm reduction/needle exchange.</p> <p>47:27 & 28. Per CHAIN's "Unconnected Revisited" report, CHAIN (5/1999) recommended: (1) Continue to expand high-intensity outreach efforts. (2) Outreach is necessary not only for entry into care, but maintenance. (3) Continue to develop and refine very low threshold "service readiness" programs (based on harm reduction models). The provision of services that address basic survival needs may be necessary enabling/intermediate steps to engage this population.</p> <p>78:1 through 4. Per a Y12 Social Services Workgroup template funding for additional early intervention services was prioritized as necessary to help link the unconnected with care. Funded programs will be required to provide HIV counseling and testing on-site or have a direct link to counseling and testing services.</p>	

Table 14: Assessment of Service Gaps and Unmet Need

Service Category	Service Gaps and Unmet Need		Special Population Issues
	Identified by People with HIV Disease	Identified by Researchers, Providers, and Others	
A	B	C	D
Permanency planning		86:1 through 4. According to McClain & Associates (2/2002), Children who are not HIV+ receive permanency planning and other services after the loss of their parent. However, since Title I limits the funding of services for non-HIV infected individuals, agencies must find other funding sources to continue serving these children.	
Referral		87:2. In its draft policy on early intervention services (12/2001), the MO/APC stated that outpatient medical care and case management service providers will be required to maintain formal, written referral relationships with agencies at key points of entry into the health care system, including HIV testing and counseling center STD clinics, emergency rooms, homeless shelters, detoxification programs, adult/juvenile detention centers, federally qualified health care centers, and Ryan White Title I Access to Care programs.	

Table 14: Assessment of Service Gaps and Unmet Need

Service Category	Service Gaps and Unmet Need		Special Population Issues
	Identified by People with HIV Disease	Identified by Researchers, Providers, and Others	
A	B	C	D
Transportation		<p>74:1. Per a Y11 Social Services Workgroup template (7/2001), current transportation services for less ambulatory clients are currently inadequate and have problematic restrictions (e.g., Medicaid allows only one trip a day, there is no coordination for clients with multiple appointments, and service is limited to primary care visits).</p>	<p>74:1. Per a Y11 Social Services Workgroup template (7/2001), providing funding for new transportation services (at least one car and driver per borough) will help improve client's ability to access needed health and social services. The Rockaways in Queens (Winter 2001 Community Forum) and Staten Island (Staten Island HIV Care Network Service Delivery Plan 2001) particularly lack transportation.</p>
Social Services in general	<p>32:13. Per a CHAIN overview report (2000), consumers report greater unmet need for social services than for medical services and social service needs are more likely to persist over time. 90% of participants say they have struggled with an unmet social services need at some point in their disease, although this has improved over time.</p>		<p>32:13. Per a CHAIN overview report (2000) client characteristics associated with unmet social service needs include race, low income, housing instability, and active substance use.</p>

Table 14: Assessment of Service Gaps and Unmet Need

Service Category	Service Gaps and Unmet Need		Special Population Issues
	Identified by People with HIV Disease	Identified by Researchers, Providers, and Others	
A	B	C	D
Other – employment-related services	<p>42:9. Per CHAIN (5/1999), 80% of participants currently do not work, but 26% of these would like to return to work.</p> <p>42:6. Per CHAIN (5/1999), job related needs of chain participants include: basic education, job skills training for those with limited education and work experience job re-entry assistance. Client's physical and mental limitations must be considered when providing these services.</p> <p>42:6. Per CHAIN (5/1999), fear of losing benefits inhibits PLWHA from seeking employment. There is a reality-base to this fear as 17% who have returned to work have lost all or part of their benefits.</p> <p>42:6. Per CHAIN (5/1999), continuation of SSI and SSDI should occur as PLWHA reenter the workforce.</p> <p>42:9. Per CHAIN (5/1999), only 14% of participants face no impediments in returning to work. Barriers include: 40% have less than a HS education, 40% have physical limitations, 20% are disabled because of substance abuse problems, >30% have low mental health functioning.</p>	<p>86:5. According to McClain & Associates (2/2002), providers reported that vocational and employment services sought by Title I clients are generally available. However, these services typically are not HIV-specific.</p> <p>93:2 & 3. Per a Policy Roundtable hosted by MTS, flexible work incentives and transitional benefits that allow for episodic realities and the unique nature of HIV disease are necessary to encourage a return to work. Relatedly, educational programs are needed that target both consumers and providers. A significant public education campaign that would address attitudes related to hiring PLWHA is also important. Lastly, the expansion of alliances and coalitions of organizations interested in this topic should be encouraged.</p>	<p>86:4. According to McClain & Associates (2/2002), travel and meals are typically provided for peer counselors, but stipends tend to be small or non-existent due to agency concerns that peers might lose public benefits if paid.</p>

Sources: Document numbers are indicated for each entry.

Table 15: Service Needs of Persons In Care and Unconnected to Care by Population

Population	Service Needs of Persons In Care	Services Needs of Persons Unconnected to Care
A	B	C
Youth	86:1 through 4. According to McClain & Associates (2/2002), service models exist for homeless adolescents, but the availability of housing and related-services appears to be low.	
AOD	95:5. According to a 3/2000 NYAM study, AODs often experience long waits for short medical visits. Waits are difficult for active users, especially during withdrawal. Users often feel stigmatized by providers who lack experience with and feel uncomfortable providing care to this population.	<p>47:11. Per CHAIN's "Unconnected Revisited" report (5/1999), the unconnected that the research team were able to locate were mostly homeless, mentally ill, substance users, or a combination of more than one of these.</p> <p>37:3. Per CHAIN (5/2000), either substance use or unstable housing (or both simultaneously) are associated with not entering primary care, or not maintaining care.</p> <p>92:5 & 6. According to an undated NYAM study, the need for syringe exchange slots vastly outstrips current capacity. 1998 data suggests that programs can only reach 15-20% of the city's IDUs and that only 2% of need would be met if the ideal of one syringe per injection were followed. Syringe exchange programs are missing from 11 of the highest need neighborhoods in NYC. Even in neighborhoods that have a program, on average only 28% of the population can be served.</p>

Population	Service Needs of Persons In Care	Services Needs of Persons Unconnected to Care	Table 15 <i>continued</i>
A	B	C	<i>Service Needs of Persons In Care and Unconnected to Care by Population</i>
Women	<p>41:3. Per CHAIN (5/1999), compared to other groups, HAART usage is lower among individuals with three or more dependent children.</p> <p>33:3. Per CHAIN (6/2000), 30% of women expressed a need for housing and housing services.</p> <p>92:12. According to an undated NYAM study, most residential drug treatment programs are not able to provide services to women with children, compounding an already existing treatment shortfall.</p>		<i>Women</i> <i>Inmates/ releasees</i>
Inmates/ releasees	<p>60:1 through 6. According to a 6/2000 AOD Workgroup template, in 1997 a total of 5,474 individuals were tested for HIV upon entrance into the NYC Correctional System. Of these 7% of men and 19% of women tested positive. This highlights the need for drug treatment, HIV education, and HIV services in prison.</p> <p>108:37. According to the Title I 2002 RFP, discharge planning and case management provided at Riker's Island for detainees and prisoners is insufficient to meet demand; some inmates are released without adequate linkage to services.</p> <p>60:1 through 4. This Y11 AOD Workgroup template states that large numbers of HIV+ inmates are discharged without receiving counseling, testing, AOD services, or community service referral and placements. This template prioritizes funding to provide a 24-hour Access, Referral and Drop-in Center for HIV+ prison releasees near the release point for Rikers Island detainees and prisoners.</p>		

Table 15 *continued*
*Service Needs of
 Persons In Care and
 Unconnected to
 Care by Population*

MICAs

Homeless

Population	Service Needs of Persons In Care	Services Needs of Persons Unconnected to Care
A	B	C
MICAs		<p>47:11. Per CHAIN’s “Unconnected Revisited” report (5/1999), the unconnected that the research team were able to locate were mostly homeless, mentally ill, substance users, or a combination of more than one of these.</p> <p>30:12 through 16. Per CHAIN (6/2000), the rates of mental health problems among PLWHA are much higher than is true of the general population. 20-25% of those PLWHA in care and 80% of those outside of care have a multiple diagnosis. 80% of those currently using drugs had mental health scores in the very low range at least once during their participation in CHAIN; 38% had very low scores at three or more interviews.</p>
Homeless	<p>86:1 through 4. According to McClain & Associates (2/2002), service models exist for homeless adolescents, but the availability of housing and related-services appears to be low.</p>	<p>47:11. Per CHAIN’s “Unconnected Revisited” report (5/1999), the unconnected that the research team were able to locate were mostly homeless, mentally ill, substance users, or a combination of more than one of these.</p> <p>37:3. Per CHAIN (5/2000), either substance use or unstable housing (or both simultaneously) are associated with not entering primary care, or not maintaining care.</p>

Sources: Document numbers are indicated for each entry.

Table 16: Unconnected to Care including HIV+ Aware Not in Care*Special Needs*

114:1. CHAIN, in a 2002 personal communication, estimates that there are between 2,520 and 7,200 HIV+ individuals in NYC who are unconnected to care.

47:11. Per CHAIN's "Unconnected Revisited" report (5/1999), the unconnected that the research team were able to locate were mostly in their 30's, of both genders, primarily African-American and Latino. Most were extremely poor. The vast majority supported themselves through the irregular economy: selling drugs or sex, stealing or fencing stolen goods, and/or panhandling. Multiple problems are common, including: incarceration, traumatic personal events, few close friends or family ties. Most were homeless, mentally ill, substance users, or a combination of more than one of these. In general, their problems were more severe than was true of those included in the 1995 unconnected study.

78:1 through 4. Many of the estimated 5,000-10,000 New Yorkers newly infected with HIV each year (Office of AIDS Research NYCDOH, 2000) have little or no contact with the HIV service delivery care system, and many do not learn of their HIV status until they suffer an AIDS related infection. The NYCDOH HIV/AIDS surveillance system (HARSA Reporting System, 2000) reports that 30% of AIDS cases are first diagnosed with an opportunistic infection. Delayed care seeking is especially high among African-Americans (source not cited).

18:4. Per CHAIN (12/2001), compared to those with a substance use history, those with no such history who are newly diagnosed make the transition to HIV+ services more smoothly, waiting a shorter time after initial diagnosis before seeking out care, and being more likely to have a referral rather than having to seek out service on their own.

108:47. According to the Title I 2002 Request for Proposals, African Americans with HIV have particularly high rates of delayed entry into HIV primary care.

30:12 through 16. Per CHAIN (6/2000), persons outside of care are three times more likely to report emotional or psychological problems than is true of those in care, 52-71% of the "unconnected" report the need for substance abuse services.

63:1. According to a 7/2001 Health Workgroup template, among 231 clients testing HIV+ at a publicly funded HIV testing site in NYC, only 57% made and kept their first medical appointment within three months of receiving their test results. In FY2000, the rate of those with HIV positive

Table 16 *continued*

*Unconnected to
Care including HIV+
Aware Not in Care*

Services

results for clients in City counseling and testing sites was 2%, and at clinical sites serving at-risk populations was 3-8%. Approximately 80% of these individuals entered ongoing HIV care (Title III data).

18:4. Per CHAIN (12/2001), those with little or no substance use history are significantly more likely to have undergone HIV testing in settings already connected to the medical system, and which can provide some continuity of care. In contrast, many high-frequency users are tested in non-medical settings that are less likely to provide that continuity. They are also less likely to have had testing recommended by a medical provider.

Services

29:15. Per CHAIN (2/2000), the provision of ancillary services (transportation, drug treatment, mental health treatment, case management, and housing services) increases the rates at which access into retention in medical care is achieved, with particularly strong results for individuals with a demonstrated need for the services in question. Ancillary services that meet complex needs – such as housing and mental illness services – have an even greater impact on getting individuals into care than in maintaining them in care (although they have a positive impact on both). This suggests that these services may be particularly important for engaging hard-to-reach populations.

23:6 & 7. Per CHAIN (7/2001), 32% of the unstably housed were delayed for three months or more in seeking HIV care compared to 20% who were stably housed. People with housing needs who get assistance are almost four times more likely to enter into medical care than those who do not get assistance. If the assistance is housing-focused case management this figure leaps to 10 times. Mental health services and ongoing self-help drug abuse services exert the greatest impact on entry into and retention in medical care among the formerly unconnected.

32:16. Per a CHAIN overview report (2000), the unconnected are nine times more likely to enter medical care if they have a case manager.

29:15. Per CHAIN (2/2000), the provision of ancillary services (transportation, drug treatment, mental health treatment, case management, and housing services) increased the rates at which access into and retention in medical care was achieved, with particularly strong results for individuals with a demonstrated need for the services in question. Ancillary services that meet complex needs – such as housing and mental illness services – have an even greater impact on getting individuals into care than in maintaining them in care (although they have a positive impact on both). This suggests that such ancillary services may be particularly important for engaging hard-to-reach populations.

107:34. Assessment Teams in the ER service category function to identify and connect HIV+ persons to care. The goals of Outstationed Medical Care Teams in SROs includes bringing at-risk populations from three geographic areas into care. The CBC Access to Care and Early Intervention category is to identify and engage HIV+ individuals outside the care system and to connect them to HIV care.

Table 16 *continued*

*Unconnected to
Care including HIV+
Aware Not in Care*

*Gaps**Gaps*

47:27 & 28. CHAIN's "Unconnected Revisited" report (5/1999) recommended: (1) Continue to expand high-intensity outreach efforts. (2) Outreach is necessary not only for entry into care, but maintenance. (3) Continue to develop and refine very low threshold "service readiness" programs (based on harm reduction models). The provision of services that address basic survival needs may be necessary enabling/intermediate steps to engage this population. (4) The unconnected need to receive better educational services on the benefit of early HIV intervention. Providers need to better understand prevailing myths and fears about HIV treatment. (5) There is much need to educate HIV providers about the unconnected -- who they are and the barriers that exist to their seeking care (including bureaucratic rules and a sense of stigma). (6) Agencies should be encouraged to enlist the help of those they already serve who have contact with the unconnected. (7) Agencies that serve this population need to work together to identify best practices and create linkages that make for a more effective network of care.

87:2. In its draft policy on early intervention services (12/2001), the MO/APC stated that outpatient medical care and case management service providers will be required to maintain formal, written referral relationships with agencies at key points of entry into the health care system, including HIV testing and counseling centers, STD clinics, emergency rooms, homeless shelters, detoxification programs, adult/juvenile detention centers, federally qualified health care centers, and Ryan White Title I Access to Care programs.

78:1 through 4. Per a Y12 Social Services Workgroup template funding for additional early intervention services was prioritized as necessary to help link the unconnected with care. Funded programs will be required to provide HIV counseling and testing on-site or have a direct link to counseling and testing services.

60:1 through 4. Per a Y11 AOD Workgroup template funding to provide 13 harm reduction escort and follow-up workers was prioritized. Workers will accompany clients to and from appointments and other activities that should help engage and maintain them in services.

Table 16 *continued*

*Unconnected to
Care including HIV+
Aware Not in Care*

Barriers

Barriers

60:1 through 4. Per a Y11 AOD Workgroup template, the unconnected have frequently had negative encounters with the health care system. This contributes to their lack of engagement with the system.

18:26. Per CHAIN (12/2001), "low threshold" services are particularly recommended as a way to improve utilization of testing by high-user AODs.

47:4 & 5. Per CHAIN (5/1999), compared to the 1995 unconnected study, outreach programs have eliminated some of the barriers to accessing care for this population.

60:1 through 4. Per a Y11 AOD Workgroup template, multi-pronged strategies are required to engage the unconnected. Approaches should be: low-threshold, easily accessible, non-judgmental, use peers when appropriate, ensure referrals to needed medical and social services.

Sources: Document numbers are indicated for each entry.

Data and Evaluation Gaps

A. Introduction

Comprehensive strategic planning begins and ends with data collection and analysis. At the beginning of the process, a needs assessment informs program planning and resource allocation decisions; at the end of the process, outcomes data help to measure program success.

This section discusses the use of data for these purposes. It also addresses data availability and data gaps in New York City as well as HRSA program evaluation requirements.

Note that a fuller understanding of the data and evaluation gaps that are present at the current time will evolve as the planning process unfolds and data needs become more obvious. This particular section thus should be viewed as a “work in progress.”

B. Data Gaps

Many of the documents listed in Table 2 report qualitative information (e.g., gathered through unstructured interviews and focus groups). This represents a data gap that requires careful consideration.

Although useful, qualitative data has a major limitation: it tends to provide rich clues as to how and why people think or behave, without examining the extent to which those beliefs or behaviors are common throughout the population. Because of this, qualitative data is not “generalizable” beyond the relatively few clients typically participating in interviews or focus groups.

Since quantitative information (epidemiological data, data from client records, logs of client behavior, and/or survey data) is typically gathered across a population or sub-population, and then summarized mathematically, it tends to be more generalizable. Thus, quantitative data is more appropriate for assessing program gaps, for decisions regarding resource prioritization, and/or for definitively stating that desired outcomes have been achieved.

New York City has an excellent resource of quantitative data available in the form of its ongoing CHAIN study, which has followed a cohort of people living with HIV/AIDS

in New York City since the mid 1990s (conducting structured interviews approximately every six months). CHAIN update reports, frequently cited throughout this document, along with HIV/AIDS surveillance data, provide the primary sources of quantitative data available to the Planning Council.

Although these sources form an excellent base from which to assess needs and determine outcomes, the size and complexity of New York City Title I programming suggests the need for multiple sources of quantitative data, using multiple data collection methods. The CHAIN study involves client self-reported data, which lacks objective third party verification. A database that tracks individual client service needs and usage over time could provide population-wide data as well as a source of more objective findings that could be used to verify CHAIN results. Additionally, data on certain sub-populations and/or specific services is scanty. To the extent that information was not available in Table 2 documents for a given sub-population and/or service, that is so noted on relevant tables throughout the text. Below is a summary of those data gaps with the relevant table number indicated:

- Utilization data for 2000-2001 (Table 9) are not available for infants/children, youth, and women.
- New client data for 2000-2001 (Table 10) are not available¹⁷ for the following service categories: primary care development in community health centers and substance abuse treatment centers; service enhancements to substance abuse treatment programs, women and children's integrated HIV services, and treatment adherence demonstration projects; treatment adherence support; assessment teams in ER/harm reduction settings; Hepatitis C screening and treatment; outstationed medical care teams in SROs; geographically targeted mental health services; and Minority HIV/AIDS Initiative ("CBC") projects: access to care, maintenance in care, treatment education, and treatment adherence consortium.¹⁸
- Data are not available on barriers to care and strategies to address them (Table 12) for infants and children.
- Data are not available on cost and outcome effectiveness (Table 13) for youth, inmates/releasees, and immigrants.
- Data are not available on service needs of persons in care (Table 15) for infants and children, men who have sex with men, and immigrants/undocumented.

¹⁷ See footnote to Table 10 for more information on reasons for these data gaps.

¹⁸ For information on these projects, see the New York Academy of Medicine's CBC initiative outcome evaluation, which examines access to care and maintenance in care programs. An additional new CBC initiative on transitional housing and supportive services to special populations and prison releasees has yet to be evaluated.

C. Using Data to Determine Service Needs and Gaps

Determining service “needs” and “gaps” is inherently difficult. For example, service delivery professionals may believe that all individuals with serious mental illness “need” professional assistance. However, as noted by CHAIN in a 2000 overview report, many participants receiving low mental health scores do not perceive the need for mental health services (32-14).

Further complicating this issue is that fact that gaps can relate to service accessibility, as well as availability. For example, although about half of the individuals who responded to a 1998 dental survey (89-Executive Summary) stated that they did not receive regular dental check-ups, further analysis shows that the reasons for this were often related to issues of accessibility -- not availability. Examples of accessibility are being uncomfortable with dental care, being in denial about the need for dental care, not knowing a dentist, concerns about HIV related stigma.

Care should be taken when judging reported service gaps, particularly given the extent to which qualitative information is reported in this needs assessment.

D. Measuring Outcomes

Congress in its reauthorizations of the CARE Act, and HRSA in its administration of the program, have embraced the notion of outcomes evaluation. CARE Act grantees are required to evaluate the effectiveness of all services funded under Title I.

HRSA's HIV/AIDS Bureau (HAB) has developed a suggested list of core outcome questions for primary care programs.¹⁹ Planning Councils are given broad discretion in developing outcome questions for other services. Further, HAB has not prescribed specific evaluation methods or models, leaving Planning Councils a reasonable amount of latitude in this regard.

Although the CHAIN study was not specifically designed to compare Ryan White funded services to non-Ryan White funded services, the Columbia team has, in fact,

¹⁹ HAB evaluation questions include: (1) To what extent are Ryan White CARE Act programs providing under served minority and vulnerable populations with access to primary care? (2) To what extent are Ryan White CARE Act programs providing clients with primary medical care whose quality meets or exceeds US Public Health Service standards or other care standards? (3) To what extent are CARE Act programs providing services that remove barriers to primary medical care so that individuals can enter into and remain in care? (4) & (5) To what extent are CARE Act programs providing services that reduce morbidity, as indicated by reductions in opportunistic infections and related hospitalizations, increases (or slowed rates of decline) in CD4 lymphocyte counts, and declines in perinatal transmission of HIV, and reduced HIV related mortality? (6) To what extent are CARE Act programs adapting to changing service and cost environments? (46-10 through 19)

devised methodologies for doing so. CHAIN Update Report #35: Assessing the Impact of the Ryan White CARE Act on Health Outcomes in New York City (25-6&7) provides a good example of this methodology.²⁰

Other CHAIN documents have successfully examined and reported on non-health care outcomes (see Table 13). Although these analyses do not specifically compare Title I funded service outcomes to the outcomes of services funded by other sources, CHAIN does possess the ability to do so upon request.

Epidemiological information, particularly addressing mortality and morbidity, also provides an excellent source of New York City outcomes data.

²⁰ Comparing Ryan White CARE Act funded services to non-CARE Act funded services, CHAIN researchers found the following: those receiving RWCA funded primary care were 60-70% more likely to report appropriate medical care, were 40-50% more likely to report being on HAART, and were 50% more likely to receive care that met HIV care guidelines; those receiving RWCA funded case management or advocacy services were 80-90% more likely to report appropriate medical care and 70% more likely to be on ARV.

Glossary and Appendix

Glossary

Barriers: Impediments in access to care, including structural (availability, how organized, transportation), financial (insurance coverage, reimbursement levels, public support), and personal (acceptability, cultural, language, attitudes, education/income).

CARE Act: Comprehensive AIDS Resources Emergency Act, also known as “Ryan White.”

CHAIN: Community Health Advisory Information Network, a longitudinal study funded by the Planning Council of 968 adults with HIV/AIDS in New York City. The study is conducted by Columbia University.

Disparities: Differences, primarily in longer-term health outcomes, between different populations or geographic regions.

Gaps: A perceived (qualitative) or measurable lack of availability or appropriateness of services or concrete needs.

Incidence: The number of new cases that occur during a specific period of time. For example, 1999 incidence is the total number of people diagnosed in 1999.

MICA: mentally ill, chemical abusers.

MSM: men who have sex with men.

Outcomes: Defined as longer-term outcomes, such as improved health status, versus intermediate outcomes, such as service utilization rates. Client satisfaction and service quality measures are also included in this category.

Overcoming Barriers: Strategies, usually programmatic, that could potentially help to overcome barriers.

Prevalence: The total number of people currently living with HIV or AIDS. For example, 1999 AIDS prevalence is the number of individuals who were diagnosed with AIDS through December 1999 still living at that time.

Quantitative data: numbers that can be statistically analyzed and are used to describe what, who, when, how many, or how much in relation to a question or issue.

Qualitative data: descriptive information usually presented in narrative form. Qualitative data can help illuminate what is happening, as well as describe how or why something is occurring.

Service Utilization: Qualitative or quantitative data that describes the service utilization patterns of a population.

Special Needs: Broad descriptions of the population and its unique cultural and/or service needs.

Targeted Services: Services that exist within the continuum of care in order to meet the unique needs of this population.

Appendix: 1999 AIDS Prevalence by Gender, Race, and Risk Factor for New York City by Zip Code of Residence

Zipcode	Gender					Race							Risk										
	Male	Female	White	Black	Hispanic	Other	MSM	IDU	Hetero	Other	Adult	Male	Female	White	Black	Hispanic	Other	MSM	IDU	Hetero	Other	Adult	
	A	B	C	D	E	F	G	H	I	J	K	L	A	B	C	D	E	F	G	H	I	J	K
10001	279	29	144	85	68	11	187	75	13	33	307												
10002	379	121	107	130	245	18	124	254	45	76	495												
10003	503	63	333	87	130	16	350	133	24	58	563												
10004	14	-	-	-	-	-	0	0	0	0	15												
10005	7	-	7	-	-	-	7	0	0	0	10												
10006	9	-	-	-	-	-	0	0	0	0	12												
10007	38	-	13	17	8	-	19	10	0	7	43												
10009	459	112	219	109	226	16	262	187	44	78	563												
10010	221	22	137	51	52	-	144	66	0	21	241												
10011	997	85	653	188	222	19	727	172	22	158	1080												
10012	172	11	110	34	29	10	116	31	0	18	183												
10013	241	8	71	102	71	-	86	119	0	31	248												
10014	542	12	445	41	61	7	482	21	0	34	554												
10016	484	46	252	148	120	10	263	179	18	68	528												
10017	63	14	31	26	18	-	45	17	0	7	77												
10018	82	20	38	38	25	-	38	43	0	8	102												
10019	346	39	193	85	93	14	241	83	8	37	383												
10020	8	-	-	-	-	-	0	0	0	0	9												
10021	258	28	211	32	36	7	192	48	19	20	285												
10022	125	11	88	21	24	-	98	11	0	14	136												
10023	307	20	210	53	54	10	239	40	9	25	327												
10024	343	31	206	81	77	10	250	66	11	40	374												
10025	735	161	254	351	280	9	370	336	63	126	890												
10026	276	146	25	310	83	-	86	191	43	98	416												
10027	362	180	51	400	89	-	123	247	65	104	535												
10028	124	16	77	32	27	-	83	30	0	17	140												
10029	553	269	56	293	468	-	134	393	104	183	805												
10030	212	107	10	261	44	-	58	153	36	72	311												
10031	333	129	30	280	149	-	123	160	66	104	457												
10032	286	92	32	166	179	-	103	144	51	78	369												

Appendix: 1999 AIDS Prevalence by Gender, Race, and Risk Factor for New York City by Zip Code of Residence

Zipcode	Gender					Race							Risk										
	Male	Female	White	Black	Hispanic	Other	MSM	IDU	Hetero	Other	Adult	A	B	C	D	E	F	G	H	I	J	K	L
	B	C	D	E	F	G	H	I	J	K	L	A	B	C	D	E	F	G	H	I	J	K	L
10033	175	43	36	51	130	-	90	60	28	38	215												
10034	129	37	39	32	95	-	65	34	30	34	163												
10035	319	169	18	288	181	-	58	258	62	105	481												
10036	375	27	189	105	104	-	278	71	18	31	402												
10037	145	56	11	168	20	-	39	92	24	41	195												
10038	38	25	19	22	22	-	19	26	6	0	60												
10039	125	87	6	180	25	-	28	105	27	50	205												
10040	110	23	23	25	82	-	58	25	18	26	133												
10041	-	-	-	-	-	-	-	-	-	-	-												
10044	22	-	6	12	-	-	9	7	0	0	24												
10048	-	-	-	-	-	-	-	-	-	-	-												
10128	99	17	59	27	26	-	72	20	0	11	116												
10280	12	-	13	-	-	-	10	0	0	0	14												
10301	85	40	47	49	29	-	32	48	23	22	124												
10302	29	13	18	16	8	-	7	22	0	0	42												
10303	28	27	11	33	11	-	0	23	6	18	54												
10304	108	47	49	74	31	-	23	88	19	12	153												
10305	36	21	39	7	11	-	9	28	6	8	54												
10306	27	16	26	-	11	-	0	15	7	0	43												
10307	6	-	8	-	-	-	0	0	0	0	10												
10308	9	-	10	-	-	-	0	0	0	0	13												
10309	39	7	16	19	11	-	0	27	0	7	44												
10310	38	19	19	25	12	-	8	33	0	6	56												
10312	23	-	23	-	-	-	8	9	0	6	28												
10314	43	16	37	6	12	-	13	16	10	8	59												
10451	236	131	10	145	207	-	48	174	61	81	360												
10452	358	213	11	251	304	-	97	228	101	143	561												
10453	338	216	20	243	290	-	54	259	96	135	532												
10454	239	142	-	125	247	-	28	188	65	94	370												
10455	196	119	10	92	208	-	34	161	46	73	305												
10456	582	351	28	518	379	8	125	441	167	194	912												

Appendix: 1999 AIDS Prevalence by Gender, Race, and Risk Factor for New York City by Zip Code of Residence

Zipcode	Gender						Race						Risk									
	Male		Female		White		Black		Hispanic		Other		MSM		IDU		Hetero		Other		Adult	
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
10457	529	278	29	323	452	-	-	101	439	121	139	797										
10458	365	187	29	170	349	-	-	96	252	92	109	541										
10459	280	146	8	157	255	6	-	48	208	75	86	418										
10460	256	157	13	162	233	-	-	53	174	77	105	402										
10461	74	32	31	27	48	-	-	13	49	10	23	104										
10462	216	127	42	138	157	-	-	63	140	66	66	336										
10463	139	48	40	60	83	-	-	48	74	21	40	184										
10464	11	8	-	6	10	-	-	0	6	0	0	19										
10465	42	24	23	20	21	-	-	10	18	11	17	63										
10466	142	85	12	132	81	-	-	28	103	40	52	221										
10467	305	131	48	147	235	6	-	97	169	81	88	429										
10468	348	151	31	167	297	-	-	97	228	82	91	490										
10469	103	66	24	101	41	-	-	22	51	42	50	165										
10470	12	9	6	7	8	-	-	0	0	0	0	20										
10471	16	6	9	-	9	-	-	10	0	0	0	22										
10472	276	129	16	139	246	-	-	50	189	65	93	391										
10473	146	112	9	104	144	-	-	23	124	60	46	251										
10474	61	37	-	37	58	-	-	12	43	8	26	93										
10475	54	22	12	46	17	-	-	16	27	16	16	75										
11001	11	-	9	-	-	-	-	0	0	0	0	14										
11003	16	-	6	10	-	-	-	0	0	0	9	19										
11004	-	-	-	-	-	-	-	0	0	0	0	-										
11101	163	36	38	81	78	-	-	54	82	19	41	193										
11102	76	22	35	25	36	-	-	42	27	12	10	96										
11103	75	12	31	6	48	-	-	50	9	0	14	87										
11104	69	6	37	8	27	-	-	46	6	0	12	74										
11105	57	18	37	11	26	-	-	25	22	11	12	75										
11106	84	31	39	23	47	6	-	48	18	19	20	115										
11201	228	52	94	117	64	-	-	119	80	24	55	273										
11203	224	108	6	294	30	-	-	39	84	59	139	321										

Appendix: 1999 AIDS Prevalence by Gender, Race, and Risk Factor for New York City by Zip Code of Residence

Zipcode	Gender					Race							Risk										
	Male	Female	White	Black	Hispanic	Other	MSM	IDU	Hetero	Other	Adult	Male	Female	White	Black	Hispanic	Other	MSM	IDU	Hetero	Other	Adult	
	A	B	C	D	E	F	G	H	I	J	K	L	A	B	C	D	E	F	G	H	I	J	K
11204	56	20	44	-	26	-	-	25	24	10	10	73											
11205	195	67	22	172	67	-	-	68	106	27	54	259											
11206	365	220	13	278	294	-	-	51	312	95	124	571											
11207	292	239	-	344	164	-	-	48	239	105	133	516											
11208	238	155	-	202	168	-	-	37	157	83	111	386											
11209	74	25	55	11	32	-	-	38	29	8	17	98											
11210	96	61	10	133	14	-	-	23	28	25	77	150											
11211	259	83	60	59	219	-	-	74	161	39	60	338											
11212	373	236	16	497	91	-	-	52	272	106	176	593											
11213	241	151	10	336	44	-	-	46	153	63	126	381											
11214	60	24	51	10	18	-	-	28	30	7	16	82											
11215	230	65	97	83	111	-	-	115	95	33	47	294											
11216	292	135	12	368	43	-	-	61	173	61	132	417											
11217	244	50	68	147	75	-	-	123	74	29	65	289											
11218	105	43	39	59	46	-	-	31	48	27	40	146											
11219	56	31	31	7	47	-	-	16	44	13	7	86											
11220	177	73	51	23	169	7	-	56	100	32	58	242											
11221	361	191	16	367	166	-	-	67	248	81	152	547											
11222	73	33	31	21	51	-	-	21	42	17	25	104											
11223	80	42	44	35	43	-	-	21	55	24	14	120											
11224	97	77	13	89	69	-	-	13	81	36	39	168											
11225	220	109	11	282	35	-	-	74	79	47	125	318											
11226	433	246	21	562	88	8	-	106	153	137	276	665											
11228	23	11	17	8	9	-	-	0	13	7	0	34											
11229	44	27	41	17	12	-	-	16	21	10	17	70											
11230	83	41	41	49	30	-	-	26	43	25	29	121											
11231	117	65	46	72	62	-	-	46	78	18	32	180											
11232	70	25	20	13	59	-	-	19	45	11	10	93											
11233	266	181	6	382	56	-	-	47	200	64	125	435											
11234	60	38	30	51	17	-	-	13	24	15	38	92											
11235	77	23	42	20	32	6	-	22	35	7	29	99											

Appendix: 1999 AIDS Prevalence by Gender, Race, and Risk Factor for New York City by Zip Code of Residence

Zipcode	Gender					Race					Risk				
	Male	Female	White	Black	Hispanic	Other	MSM	IDU	Hetero	Other	Adult				
	A	B	C	D	E	F	G	H	I	J	K	L			
11236	112	79	31	133	26	-	-	17	56	45	68	186			
11237	196	115	16	57	237	-	-	36	146	49	78	299			
11238	319	129	40	360	45	-	-	134	149	39	119	444			
11239	36	13	11	33	-	-	-	7	13	0	11	47			
11354	50	15	18	16	27	-	-	27	19	0	8	65			
11355	91	35	39	35	42	10	-	38	42	14	18	125			
11356	20	6	19	-	-	-	-	6	6	0	0	26			
11357	30	9	27	-	7	-	-	10	13	0	0	38			
11358	28	10	19	8	9	-	-	7	11	0	8	38			
11359	-	-	-	-	-	-	-	0	0	0	0	-			
11360	14	-	14	-	-	-	-	9	0	0	0	18			
11361	14	6	14	-	-	-	-	0	0	0	0	20			
11362	8	-	8	-	-	-	-	0	0	0	0	12			
11363	10	-	7	-	-	-	-	6	0	0	0	11			
11364	7	6	9	-	-	-	-	0	0	0	0	12			
11365	36	20	15	23	13	-	-	13	8	11	10	55			
11366	8	-	-	8	-	-	-	0	0	0	0	13			
11367	30	10	11	14	12	-	-	0	14	0	9	40			
11368	175	59	23	83	124	-	-	67	64	38	63	230			
11369	72	66	12	72	54	-	-	23	68	13	26	138			
11370	592	141	79	337	313	-	-	51	497	13	165	732			
11371	-	-	-	-	-	-	-	0	0	0	0	-			
11372	257	34	68	19	193	11	-	180	30	37	33	291			
11373	228	30	47	26	171	14	-	150	50	22	31	255			
11374	51	16	30	11	23	-	-	26	8	10	14	66			
11375	70	16	44	12	26	-	-	45	9	6	13	85			
11377	155	26	48	21	104	8	-	90	38	18	32	180			
11378	45	10	30	-	21	-	-	14	16	0	12	55			
11379	33	6	25	-	11	-	-	18	7	0	0	38			
11385	109	79	69	14	105	-	-	25	67	34	56	184			

Appendix: 1999 AIDS Prevalence by Gender, Race, and Risk Factor for New York City by Zip Code of Residence

Zipcode	Gender					Race							Risk										
	Male	Female	White	Black	Hispanic	Other	MSM	IDU	Hetero	Other	Adult	Male	Female	White	Black	Hispanic	Other	MSM	IDU	Hetero	Other	Adult	
	A	B	C	D	E	F	G	H	I	J	K	L	A	B	C	D	E	F	G	H	I	J	K
11411	59	19	8	57	13	-	-	8	25	9	25	77											
11412	78	55	-	122	6	-	-	19	51	19	37	130											
11413	70	39	-	98	8	-	-	15	33	12	44	103											
11414	26	9	27	-	-	-	-	0	13	0	6	33											
11415	54	7	25	12	21	-	-	36	7	6	11	61											
11416	38	17	18	11	25	-	-	10	23	10	8	54											
11417	31	10	15	8	14	-	-	11	9	0	0	41											
11418	52	21	19	16	32	6	-	18	10	9	25	72											
11419	51	20	15	28	26	-	-	20	16	10	14	70											
11420	67	40	12	72	21	-	-	16	40	18	28	104											
11421	52	21	21	8	44	-	-	19	27	12	7	73											
11422	30	21	-	42	-	-	-	6	0	12	21	50											
11423	54	32	6	67	11	-	-	16	20	10	35	84											
11426	8	-	-	-	-	-	-	0	0	0	0	12											
11427	26	13	9	27	-	-	-	9	8	0	14	38											
11428	22	16	8	18	11	-	-	11	0	10	6	38											
11429	69	36	-	90	10	-	-	8	28	18	45	101											
11430	-	-	-	-	-	-	-	0	0	0	0	-											
11432	118	66	21	110	49	-	-	31	53	31	66	181											
11433	80	52	-	120	9	-	-	7	73	22	28	128											
11434	130	71	8	179	12	-	-	29	84	21	59	191											
11435	120	59	15	121	35	8	-	34	55	26	57	174											
11436	42	16	-	48	-	-	-	6	27	0	12	58											
11691	99	75	16	125	29	-	-	17	67	32	52	166											
11692	24	25	-	39	6	-	-	6	7	14	13	48											
11693	12	17	10	12	7	-	-	0	14	6	0	28											
11694	-	18	20	10	6	-	-	0	18	9	0	36											
11695	-	-	-	-	-	-	-	-	-	-	-	-											
11697	-	-	-	-	-	-	-	0	0	0	0	-											

Source: High Needs Index II (document 056)