



*CHAIN Report 2003\_7*

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Strategic Plan  
Progress Indicators:  
New Cohort Update

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## SUMMARY FINDINGS

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Health & Human Services  
HIV Planning Council

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**Originally submitted Jan 30 2004**  
**Revised April 20, 2004**  
**HRSA Grant # H89 HA 0015-13**

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**C.H.A.I.N. REPORT**

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## ACKNOWLEDGMENTS

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

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

### **Tri-County CHAIN Project**

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This research was made possible by grant number H89 HA 0015-13 from the US Health Resources and Services Administration (HRSA) HIV/AIDS Bureau. The CHAIN study is supported by the HIV Health and Human Services Planning Council of New York under a Title I grant of the Ryan White Comprehensive AIDS Resource Emergency Act of 1990 through the New York City Department of Health. It is conducted under the auspices of the Medical and Health Research Association of New York City, Inc, and in Tri-County under the Westchester Department of Health. Its contents are solely the responsibility of the researchers and do not necessarily represent the official views of the U.S. Health Resources and Services Administration; the City of New York; Putnam, Rockland, or Westchester counties; or the Medical and Health Research Association of New York.

## **INTRODUCTION**

During 2002, a comprehensive strategic plan for the organization and delivery of HIV/AIDS services was prepared for New York's Title I Planning Council[1]. The centerpiece of this plan is a set of goals and objectives developed by each of the planning council's work groups[2]. Specific objectives pertaining to goals of the Tri-County Region were included. For each objective, a performance measure was defined to monitor progress towards achieving each objective. For many of the objectives it was possible to construct the performance measures from New York City and Tri-County CHAIN interview data. This document is the first in what is planned to be an annual series of reports summarizing the CHAIN measures assembled from annual interviews with the CHAIN cohorts. Baseline values are presented for each objective, which will serve as a basis for comparing progress in achieving planning council objectives in future years.

To assist the reader in navigating through this document, a brief summary of the organization of this report is presented below. Definitions for each CHAIN measure were developed for the strategic plan[3]. Each measure is constructed as a dichotomy which illustrates how well CHAIN participants' experiences relate to the stated performance criteria. Summary tables listing objectives and progress indicators compare the New York City and Tri-County CHAIN cohorts on Baseline measures. The Tri-County cohort is furthered compared longitudinally on each objective indicating notable changes over time.

Following the summary tables, baseline statistics for each objective are summarized on a single page in graph form. Each page details the progress of a single objective by ethnicity, county of residence, risk group and gender. Objectives are organized by work groups and goals within work groups. The heading of each page identifies the work group, the objective number and a statement of the objective. The numerical prefix of the objective corresponds to the number of the work group goals. For example, Health Services Work Group Objective 1A is the first objective for Goal 1 of this work group. Readers interested in the wording of work group goals should refer to the Strategic Plan Report. The "progress indicator" for the objective is then defined. Tri-County Baseline and Wave 2 values are reported for each progress indicator. Two bars for each category (males and females, major ethnic groups, HIV risk categories, county of residence) are presented. The above bar (black color) presents baseline values for each group collected in 2002, and the below bar (red color) presents values for the Wave 2 follow up, which was conducted in 2003.

[1] McClain and Associates, Inc. New York EMA Comprehensive Strategic Plan for HIV/AIDS Services 2002-2005.

[2] Ibid pp.58-87.

[3] Ibid pp.96-123

**Strategic Plan: HEALTH Work Group Objectives**  
CHAIN Performance Measures, last updated April 13 2004

<b>Obj #</b>	<b>Objective</b>	<b>Progress Indicator</b>	<b>% of NYC CHAIN cohort with Positive Indicator (1998-2001), n=652</b>	<b>% of Tri-County Wave 1 cohort with Positive Indicator (2002-2003), n=398</b>	<b>% of Tri-County Wave 2 cohort with Positive Indicator (2003-2004), n=315</b>	<b>Groups in Tri-County Wave 2 cohort with statistically lower progress</b>
1A-1	PLWHA will have improved survival and health outcomes	Self-reported health status score is at or above national average for “good health”	<b>48%</b>	<b>45%</b>	<b>41%</b>	1. Problem drug users 2. MSM&PDU
1A-2	PLWHA will have improved survival and health outcomes	Self-reported CD4 count is greater than 500 cells/mm <sup>3</sup>	<b>34%</b>	<b>33%</b>	<b>30%</b>	1. Men
1B	Persons who receive health services will adhere to treatment	Self-reported adherence to HIV medications	<b>67%</b>	<b>63%</b>	<b>66%</b>	1. Problem drug users
3A-1	PLWHA in care will receive services that meet or exceed AI quality standards	Reported medical care that met minimal preferred practice guidelines	<b>71%</b>	<b>68%</b>	<b>75%</b>	
3B	PLWHA report health-related quality of life as good or better	Self-reported health is “good,” “very good,” or “excellent”	<b>66%</b>	<b>67%</b>	<b>61%</b>	1. Problem drug users

*\* Percentage reported in Wave 2 is statistically significantly different than that reported in Wave 1*

**Strategic Plan: HOUSING Work Group Objectives**  
 CHAIN Performance Measures, last updated April 13 2004

<b>Obj #</b>	<b>Objective</b>	<b>Progress Indicator</b>	<b>% of Baseline CHAIN cohort with Positive Indicator (1998-2001), n=652</b>	<b>% of Tri-County Wave 1 cohort with Positive Indicator (2002-2003) n=398</b>	<b>% of Tri-County Wave 2 cohort with Positive Indicator (2003-2004), n=315</b>	<b>Groups in Tri-County Wave 2 cohort with statistically lower progress</b>
1A-1	Transitional housing will be available to PLWHA who need it	Percent who reported being unstably housed, who had any episode of living on street, in shelter, SRO, or doubled-up with friend or relative in past 6 months	<b>18%</b>	<b>18%</b>	<b>10%</b>	
2A	Housing placement assistance services will be available for PLWHA who need them	Among those who reported any unstable housing, percent who received housing subsidy, lived in specialized AIDS housing, or received housing services	<b>33%</b>	<b>21%</b>	<b>15%</b>	

*\* Percentage reported in Wave 2 is statistically significantly different than that reported in Wave 1*

**Strategic Plan: AOD Work Group Objectives**  
 CHAIN Performance Measures, last updated April 13 2004

<b>Obj #</b>	<b>Objective</b>	<b>Progress Indicator</b>	<b>% of Baseline CHAIN cohort with Positive Indicator (1998-2001), n=652</b>	<b>% of Tri-County Wave 1 cohort with Positive Indicator (2002-2003), n=398</b>	<b>% of New CHAIN cohort with Positive Indicator (2003-2004), n=315</b>	<b>Groups in Tri-County Wave 2 cohort with statistically lower progress</b>
1A	Health care/mental health and other providers will understand AOD culture and provide culturally appropriate and sensitive treatment to AOD users	Among those who reported current or past drug use, the percent who delayed or did not get medical or social services because of barriers experienced	<b>18%</b>	<b>26%</b>	<b>44%</b>	
1B	Health care, mental health, and other services will be more available and accessible to AOD users	Among those who reported current or past drug use, and who had an objective need for mental health services (a low mental health score on a standardized scale), the percent who reported they received professional or supportive mental health services	<b>50%</b>	<b>53%</b>	<b>53%</b>	1. Males

*\* Percentage reported in Wave 2 is statistically significantly different than that reported in Wave 1*

**Strategic Plan: SOCIAL SERVICES Work Group Objectives**

CHAIN Performance Measures, last updated April 13 2004

<b>Obj #</b>	<b>Objective</b>	<b>Progress Indicator</b>	<b>% of Baseline CHAIN cohort with Positive Indicator (1998-2001), n=652</b>	<b>% of Tri-County Wave 1 cohort with Positive Indicator (2002-2003), n=398</b>	<b>% of Tri-County Wave 2 cohort with Positive Indicator (2003-2004), n=315</b>	<b>Groups Tri-County Wave 2 cohort with statistically lower progress</b>
1B	PLWHA will have access to culturally competent and linguistically appropriate social services	Percent who delayed or did not get medical or social services because staff did not speak their language; were not competent to deal with problem; were not polite, respectful or sensitive; did not understand their problem; or did not listen to their problem or needs	<b>15%</b>	<b>28%</b>	<b>41%</b>	
1C	PLWHA will have access to necessary transportation services	Among those who reported needing help with transportation, or who said it was a barrier to receiving care, percent who received transportation services	<b>45%</b>	<b>43%</b>	<b>29%</b>	
1D	PLWHA will have access to a broad range of support, advocacy and basic needs programs within their geographic area	Among those who reported needing help with legal matters, child care, or food/ groceries/ meals, percent who said “no change has occurred,” “no progress has been made,” or the “problems have been getting worse”	<b>53%</b>	<b>47%</b>	<b>32%</b>	1. Rockland
3B	PLWHA will have increased knowledge regarding treatment issues and adherence strategies	Among those who received help with taking meds, percent who reported the advice was “very helpful” or “somewhat helpful”	<b>91%</b>	<b>85%</b>	<b>85%</b>	1. Rockland
4A	Unmet benefit need [add language from Plan]	Among those who had need for benefits (annual household incomes below \$10,000 and t-cell counts below 200) percent on Medicaid	<b>98%</b>	<b>91%</b>	<b>96%</b>	

*\* Percentage reported in Wave 2 is statistically significantly different than that reported in Wave 1*

**Strategic Plan: MENTAL HEALTH Work Group Objectives**

CHAIN Performance Measures, last updated April 13 2004

<b>Obj #</b>	<b>Objective</b>	<b>Progress Indicator</b>	<b>% of Baseline CHAIN cohort with Positive Indicator (1998-2001), n=652</b>	<b>% of Tri-County Wave 1 cohort with Positive Indicator (2002-2003), n=398</b>	<b>% of Tri-County Wave 2 cohort with Positive Indicator (2003-2004), n=315</b>	<b>Groups in Tri-County Wave 2 cohort with statistically lower progress</b>
1B-1	PLWHA engaged in mental health care will adhere to treatment	Among those with an objective need for mental health services (a very low MH score on a standard scale), percent who reported being fully adherent to HIV meds	<b>61%</b>	<b>49%</b>	<b>60%</b>	
1B-2	PLWHA engaged in mental health care will adhere to treatment	Among those with an objective need for mental health services (a very low MH score on a standard scale), and who reported receiving professional or supportive MH services, percent who reported being fully adherent to HIV meds	<b>58%</b>	<b>42%</b>	<b>57%</b>	
1C-1	PLWHA engaged in mental health care will have improved quality of life	Among those with an objective need for mental health services (a very low MH score on a standard scale), percent reporting good physical health (based on high score on standard scale)	<b>28%</b>	<b>31%</b>	<b>25%</b>	1. Problem drug users
1C-2	PLWHA engaged in mental health care will have improved quality of life	Among those with an objective need for mental health services (a very low MH score on a standard scale), and who received professional OR supportive MH services, percent reporting good physical health (based on high score on standard scale)	<b>28%</b>	<b>36%</b>	<b>25%</b>	

*\* Percentage reported in Wave 2 is statistically significantly different than that reported in Wave 1*

**Strategic Plan: TRI-COUNTY REGION OBJECTIVES**  
 CHAIN Performance Measures, last updated April 13 2004

Obj #	Objective	Progress Indicator	% of Baseline CHAIN cohort with Positive Indicator (1998-2001), n=652	% of Tri-County Wave 1 cohort with Positive Indicator (2002-2003), n=398	% of Tri-County Wave 2 cohort with Positive Indicator (2003-2004), n=315	Groups in Tri-County Wave 2 cohort with statistically lower progress
1A	Clients and providers will know what to do to access the services they need	Respondents are aware of and know how to access resources available to them	--	63%	53%	1. Latino 2. Rockland

*\* Percentage reported in Wave 2 is statistically significantly different than that reported in Wave 1*

## Strategic Plan: Multivariate Analysis

**Preface:** In considering sub-group differences, readers should consider that certain group characteristics may cluster together, thus making a determination of the most significant effect difficult to establish. For example, if most Latino men in the Tri-County CHAIN cohort live in Urban Westchester, and they tend to be healthier with t-cell counts over 500, than when one looks at self-reported health status and sees “men,” “Latinos,” and people living in Urban Westchester, one cannot tell if all men in the cohort are healthier than women, or if this is being driven by the preponderance of healthier Latino men in Urban Westchester. In order to estimate the individual effects more accurately, we have conducted a multivariate regression analysis, which looks at all the effects together. What this analysis does is look at each effect as if all the other factors are equal. In our example, the analysis would look at men, controlling for such other effects as being Latino, living in Urban Westchester, or having a high t-cell count. If after conducting this analysis men are still significantly healthier, this holds regardless as to whether the men are Latinos, live in Urban Westchester, or have high t-cell counts. The following illustrates the major factors associated with five of the major outcomes or performance measures used in the Strategic Plan.

<i>Factors most significantly associated with...</i>				
<b>Reporting a lower physical health score</b>	<b>Being adherent to HIV medications</b>	<b>Reporting comprehensive medical care (provider available 24 hours, for well-visit, and for health advice)</b>	<b>Not know how to access services available</b>	<b>Experiencing barriers to medical or social services care</b>
<ul style="list-style-type: none"> <li>– T-cell less than 500</li> <li>– Less than high school education</li> </ul>	<ul style="list-style-type: none"> <li>–Having comprehensive medical care</li> <li>– No problem drug use</li> <li>–Being over age 50</li> <li>– Not having low MH</li> </ul>	<ul style="list-style-type: none"> <li>–Having a case manager</li> <li>– Not having low MH</li> </ul>	<ul style="list-style-type: none"> <li>– Having ever used drugs</li> <li>– Living in Rockland, Sub Westchester, or Putnam</li> <li>– Not having low MH</li> <li>– Diagnosed between 1990-1995</li> <li>– Attending AA/NA or self help program</li> </ul>	<ul style="list-style-type: none"> <li>– Having low MH</li> <li>– Unstable housing</li> <li>– Not attending AA/NA or self help</li> </ul>

*Note: This analysis considered the following potential factors for each outcome – gender, race/ethnicity, HIV risk category, county of residence, age group, year of diagnosis, household income, educational level, unstable housing arrangements, receipt of housing services, use of mental health services, drug use history, drug treatment services including AA/NA or other self help programs, mental and physical health scores, having a case manager, continuity of medical care, comprehensive medical care ,and t-cell count.*

## **KEY FINDINGS**

Key findings from Tri-County CHAIN Wave 2 interviews are specified below and categorized by issue area. Graphs for each objective follow the summaries and offer the reader a visual aide to assess changes within the cohort and within sub-groups.

### **HEALTH SERVICES**

Current physical health status was measured in three domains, self reported assessment, measurement of clinical markers, and estimates of appropriate medical care. Self reported physical health was measured in two ways. The more subjective measure was a single global question rating current health from excellent to poor. A more objective measure of physical health was calculated by the Physical Component Summary Scale (PCS) of the SF36, which is a standardized set of questions that correlate with stage of disease. The second component, clinical markers, included self-reported T-cell counts and adherence to medication schedules. A third element used to measure health status were questions adapted from the AIDS Institute to assess the quality of primary care and components the World Health Organization's guidelines for comprehensive medical.

- Self reported assessment indicated slightly poorer physical health from Wave 1 to Wave 2 (Objective 1A-1). Scores on the PCS did not vary considerably by county of residence or by gender. However, ethnicity appears to be associated with self reported physical health outcomes. Black respondents reported poorer health more often than White or Latino respondents over time. In both rounds of interviews there was a considerable difference in self reported physical health between men who have sex with men and problem drug users. MSM were more likely to report better physical health on both the PCS and on the global question measuring overall health status than PDUs (Objective 3B).
- Clinical markers of health status appear to be stable over the two waves of interviews. The percent of respondents with T-cell counts over 500 remained steady as did the percent of respondents who reported complete adherence to medication. Differences in clinical markers are noted within groups. MSM tend to report being completely adherent more often than other risk groups, and noticeable more than PDU's. This finding has been consistent over both interviews( Objective 1B).
- A slightly higher proportion of women participating in Wave 2 indicated they were on anti-retrovirals and they reported being more adherent to medication regimes in recent interviews than they reported in during the baseline.
- A significant percent of men compared to women were more likely to report T-cell counts lower than 500 in Wave 2, which was not noted in Wave 1. This change was constant when follow up and attrition rates were considered (Objective 1A-2).

Assessment of clinical care was made by two modules. One set of questions, developed at the AIDS Institute, measures appropriate medical care using three criteria. They include the number of visits reported over a period of time, a report of a complete physical exam and recent blood work. The presence of these three components meets the standard for appropriate care as

set by the AIDS Institute. The second module measures comprehensive care by the availability of three factors. Primary care is considered to be comprehensive if a 24 hour service is available for patient in crisis, and health advice is available through the provider, and if patients can be seen for well visits.

- The percent of respondents reporting appropriate medical care increased over time, however, there was no significant difference between waves or within groups. The proportion of respondents indicating they received comprehensive medical care was stable across the two waves of interviewing. The percentage of Latino respondents reporting comprehensive care remained relatively stable compared to the percentage of Blacks and Whites receiving comprehensive care.

### **ALCOHOL OR OTHER DRUGS**

- From Wave 1 to Wave 2 respondents who have ever used drugs indicated an increase in the proportion of times they delayed or did not get care because of inter-personal barriers they perceived with providers. These barriers included being misunderstood by providers, feeling staff were insensitive or rude, or feeling staff were not competent to deal with their problems (Objective 1A). Problem drug users reported significantly more difficulties with staff that resulted in a delay, or decline of services by the respondent.
- For those respondents who were current or past drug users and who expressed a need for mental health services the proportion receiving services remained stable. However, men were less likely than women to actually receive services when they had a need (Objective 1B). The difference in accessing services by gender was not noted in Wave 1 interviews, and attrition analysis did not diminish the discrepancy.

### **SOCIAL SERVICES**

- The overall proportion of respondents indicating they experienced a cultural or language barrier within the care system increased substantially between waves (Objective 1B). This finding is not linked to follow up rates or attrition, but most likely a product of recall bias, or participation in the interview itself.
- Solely in Wave 2, geography was associated with experiencing a cultural or language barrier. Rockland residents were also more likely to report experiencing this obstacle with agency staff.
- Among those with a need for transportation services in Wave 2, Rockland residents were considerably more likely to receive the service than those in need of transportation and living in urban Westchester (Objective 1C). Black and Latino respondents expressing a need for transportation were less likely than white respondents to receive the service.
- The proportion of respondents expressing need remained relatively stable, however wave 2 respondents were more likely to report that progress was made with problems involving food or groceries, child care or legal matters (Objective 1D). A substantial decrease was noted by two groups. More often in Wave 2 problem, drug users and Urban Westchester residents reported progress in resolving issues with social services. A bias analysis indicates attrition has no effect on these results.

- For those respondents receiving help with adhering to medication regimes (Objective 3B), the effectiveness of the assistance they received remained stable over time. Urban Westchester residents were more likely to say the help they received was useful in Wave 2 interviews.

## **MENTAL HEALTH**

Mental Health was assessed by the Mental Health Component Summary, MCS, of the SF36. Rates of adherence to medication were measured for people with very low mental health both taking into account receipt of mental health services and regardless of whether mental health services were reported.

- For respondents with an MCS score below 37, indicating an objective need for mental health services, adherence to medication schedules increased slightly between waves whether they received mental health services or not (Objectives 1B-1, 1B-2). Self-reported adherence did not differ by ethnicity, gender, location, or risk category for respondents with low mental health scores.
- Self-reported physical health was poorer in wave 2 when compared to wave 1 for those respondents with low mental health scores (Objective 1C-1). Within this group, problem drug users as compared to other risk categories, were more likely to be in poorer health whether they received mental health services or not (Objective 1C-2).

## **ACCESS TO SERVICES**

- Respondents indicated a decreased awareness in the availability of HIV-related resources and how to access them over time (Objective 1A). A smaller percentage of Wave 2 respondents knew where to find help with HIV compared to Wave 1 respondents. Latino respondents were considerably less likely than Black or White respondents to delay or not get the services they needed because they did not know how to find them. Rockland residents were less likely to know how to find and access services than people living in Westchester or Putnam. Attrition did not account for this differential.

## **HOUSING**

- Housing stability did not vary between gender, ethnicity, location or risk group in either round of interviews (Objective 1A) . In Wave 2, however, noticeably lower proportion of respondents reported being unstably housed or receiving a housing subsidy, or needed transitional housing in six months prior to the interview (Objective 2A) . However, closer examination reveals these measures are a consequence of attrition in the cohort. The respondents remaining in the study were more likely to have stable housing than the respondents who were deemed ineligible- moved, deceased, etc., or not interviewed in Wave 2. Further reporting of housing status in the Tri-County CHAIN cohort is in progress.

## Health Service: Objective 1A-1

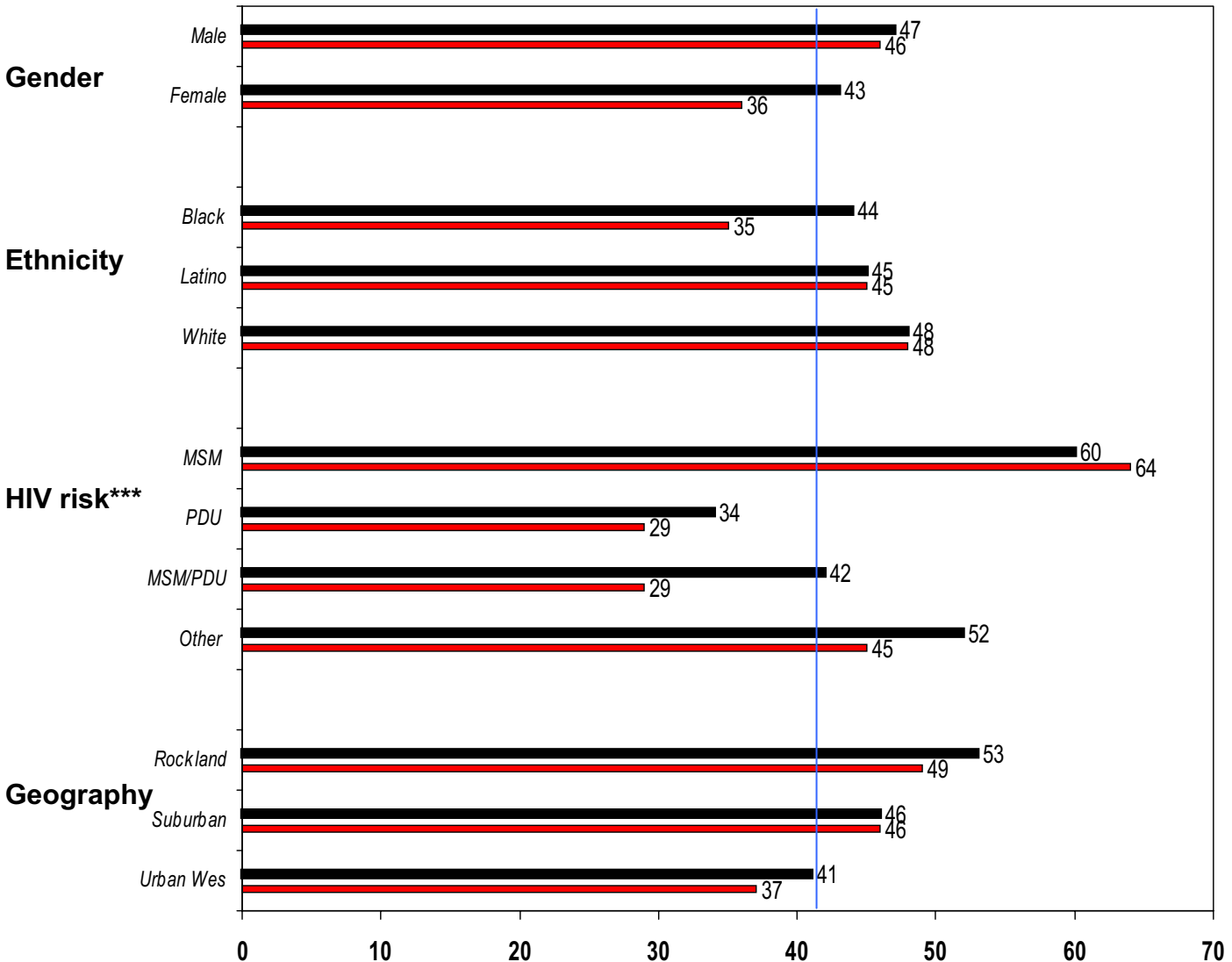
Persons with HIV disease engaged in health care services will have improved survival and health outcomes.

PROGRESS INDICATOR: Self-reported health status, as measured by a standardized multi-item health score.

Baseline: 45 percent with PCS score of 45 or higher

Wave II: 41 percent with PCS score of 45 or higher

Wave II  
Average



\*\*\*< 0.001

Wave I data  
Wave II data

## Health Service: Objective 1A-2

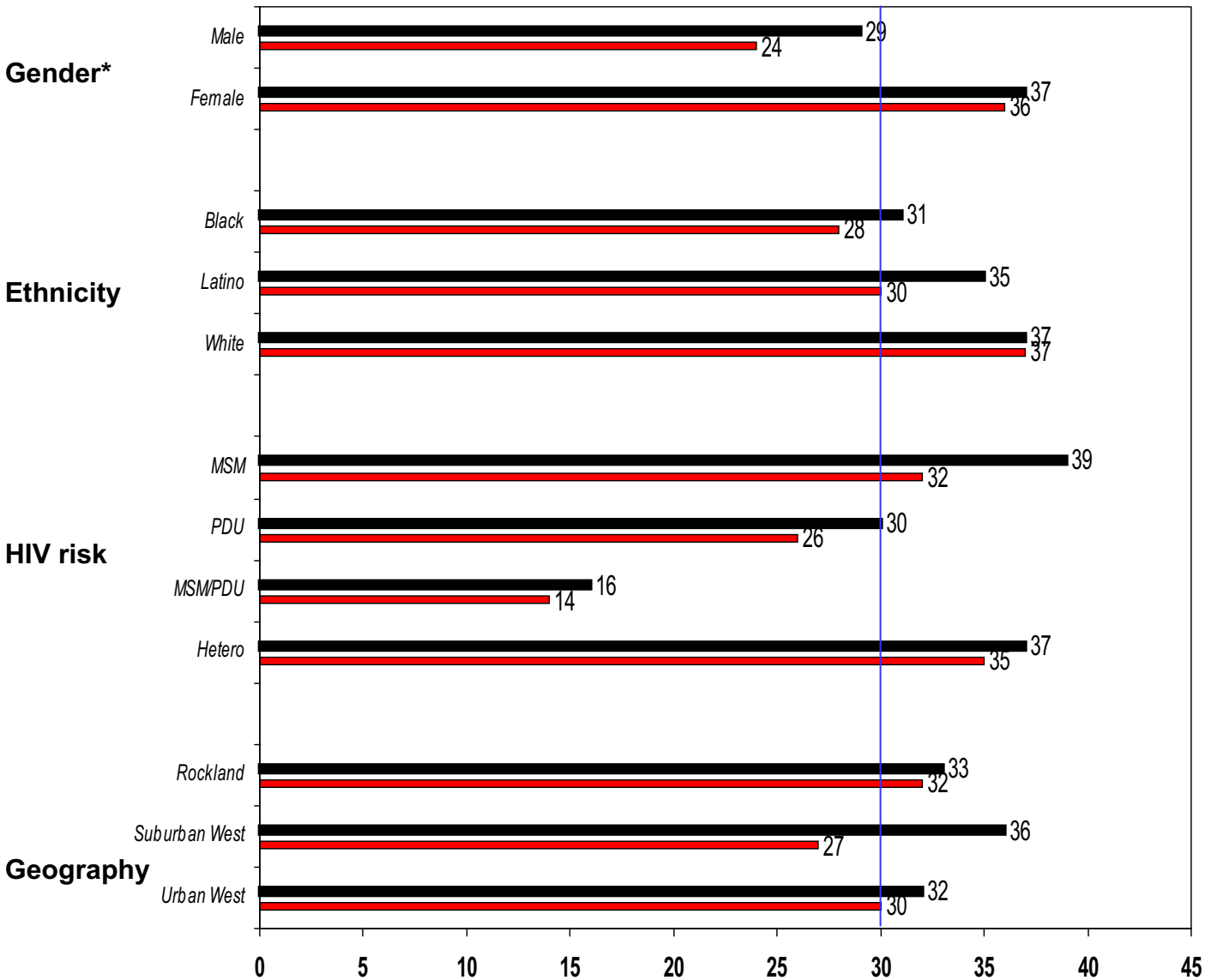
Persons with HIV disease engaged in health care services will have improved survival and health outcomes.

PROGRESS INDICATOR: Most recent self-reported T-cell count.

Baseline: 33 percent (reporting T-cell count of 500+)

Wave II: 30 percent (reporting T-cell count of 500+)

Wave II  
Average



\*<0.05

Wave I data  
Wave II data

# Health Service: Objective 1B

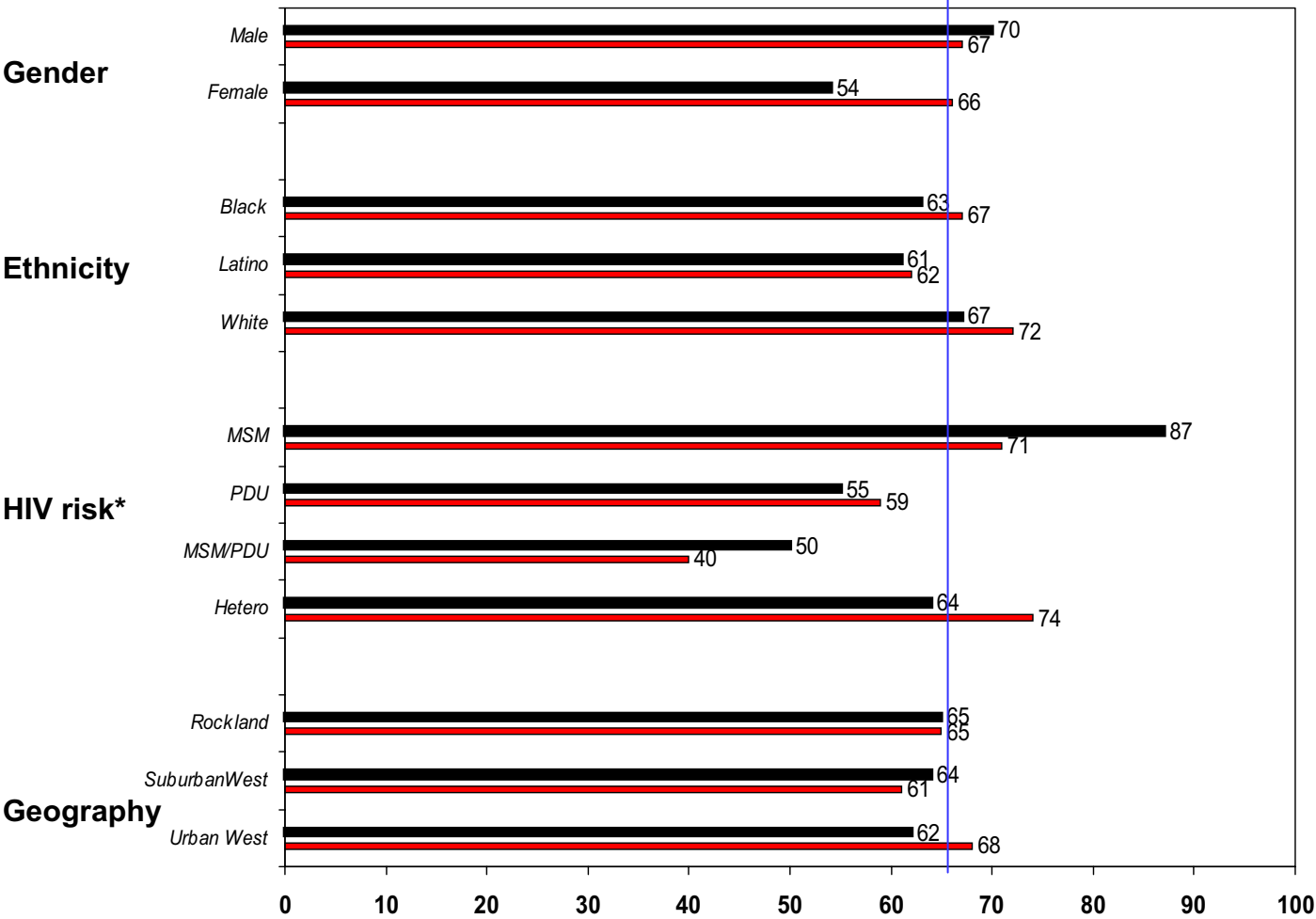
Persons who receive health services will adhere to treatments.

PROGRESS INDICATOR: Self-reported adherence to HIV antiretroviral medication, plus no reported missed pills in the two days prior to interview.

Baseline: 63 percent (completely adherent)

Wave II: 66 percent (completely adherent)

Wave II  
Average



\*<0.05

WAVE I data  
 WAVE II data

## Health Service: Objective 3A

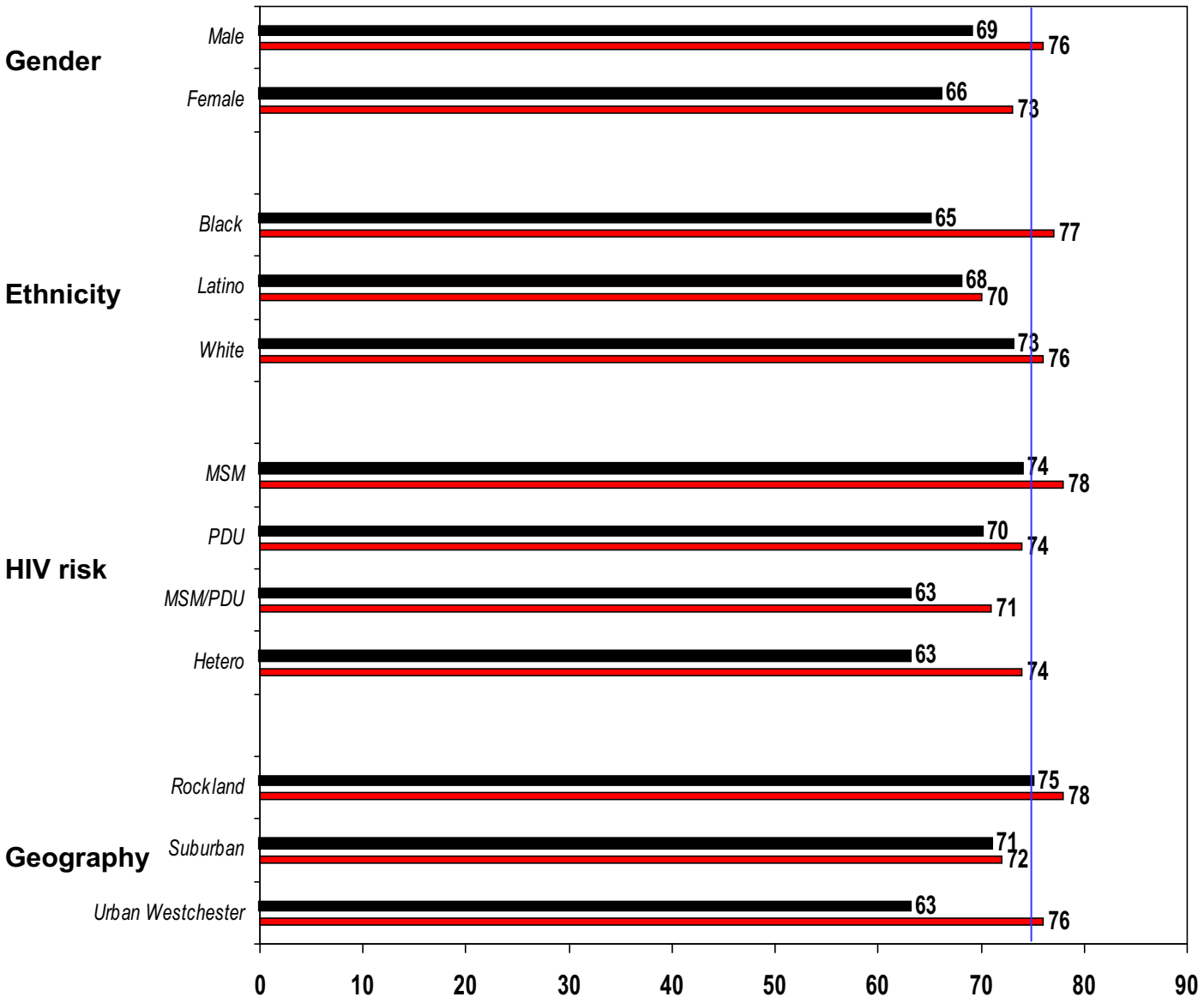
Persons with HIV disease who are in care receive services that meet or exceed the quality standards of the New York State AIDS Institute (AI).

PROGRESS INDICATOR: Met 3 AI criteria for appropriate medical care: minimum number of medical visits, complete physical exam, and a blood workup.

Baseline: 68 percent

Wave II\*: 75 percent

Wave II  
Average



\*<0.05

Wave I data  
 Wave II data

## Health Service: Objective 3B

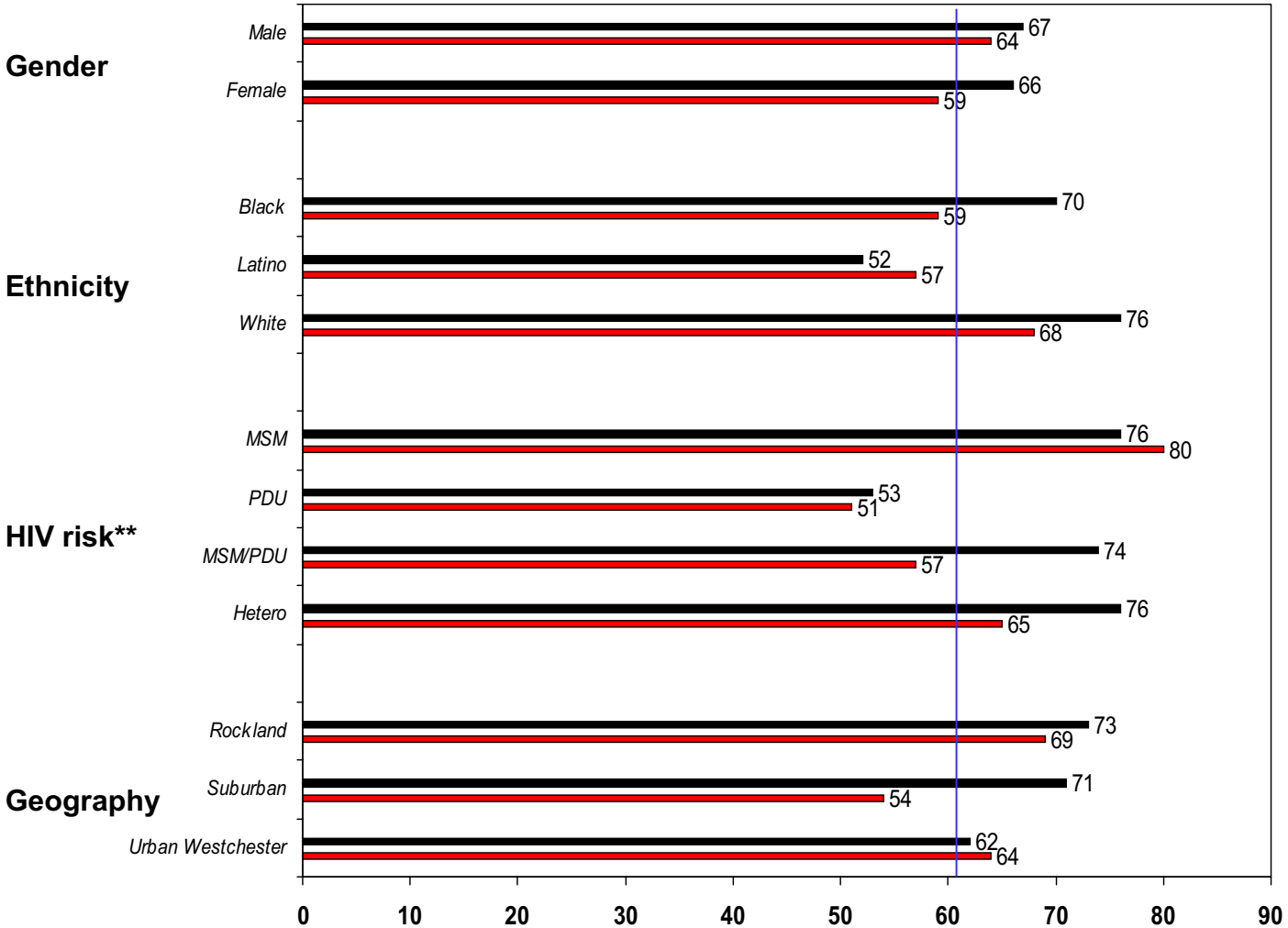
Persons with HIV disease report their health-related quality of life as “good” or better.

PROGRESS INDICATOR: Single global question measuring self-reported health status: “In general, would you say your health is excellent, very good, good, fair or poor?” (reporting “excellent,” “very good,” or “good”)

Baseline: 67 percent

Wave II: 61 percent

Wave II  
Average



\*\*<0.01

 WAVE I data  
 WAVE II data

## Health Service: Objective 3A-2

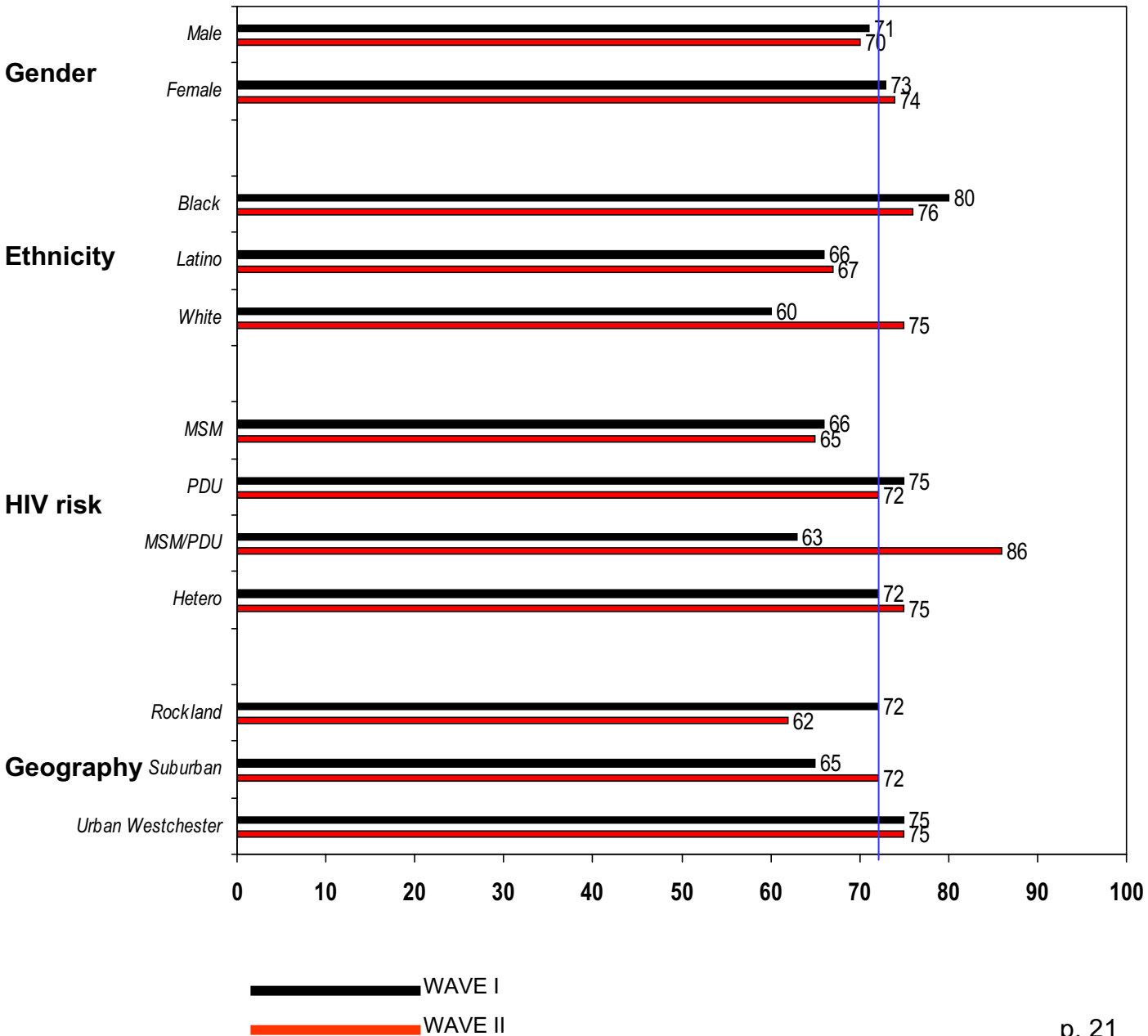
Persons with HIV disease who are in care receive services that meet or exceed the quality standards of the New York State AIDS Institute (AI).

PROGRESS INDICATOR: Respondents report receiving comprehensive medical care, defined as a primary medical provider available for “well visits,” health advice or information, and accessible 24 hours a day if needed.

Baseline: 72 percent

Wave II: 73 percent

Wave II  
Average



## AOD: Objective 1A

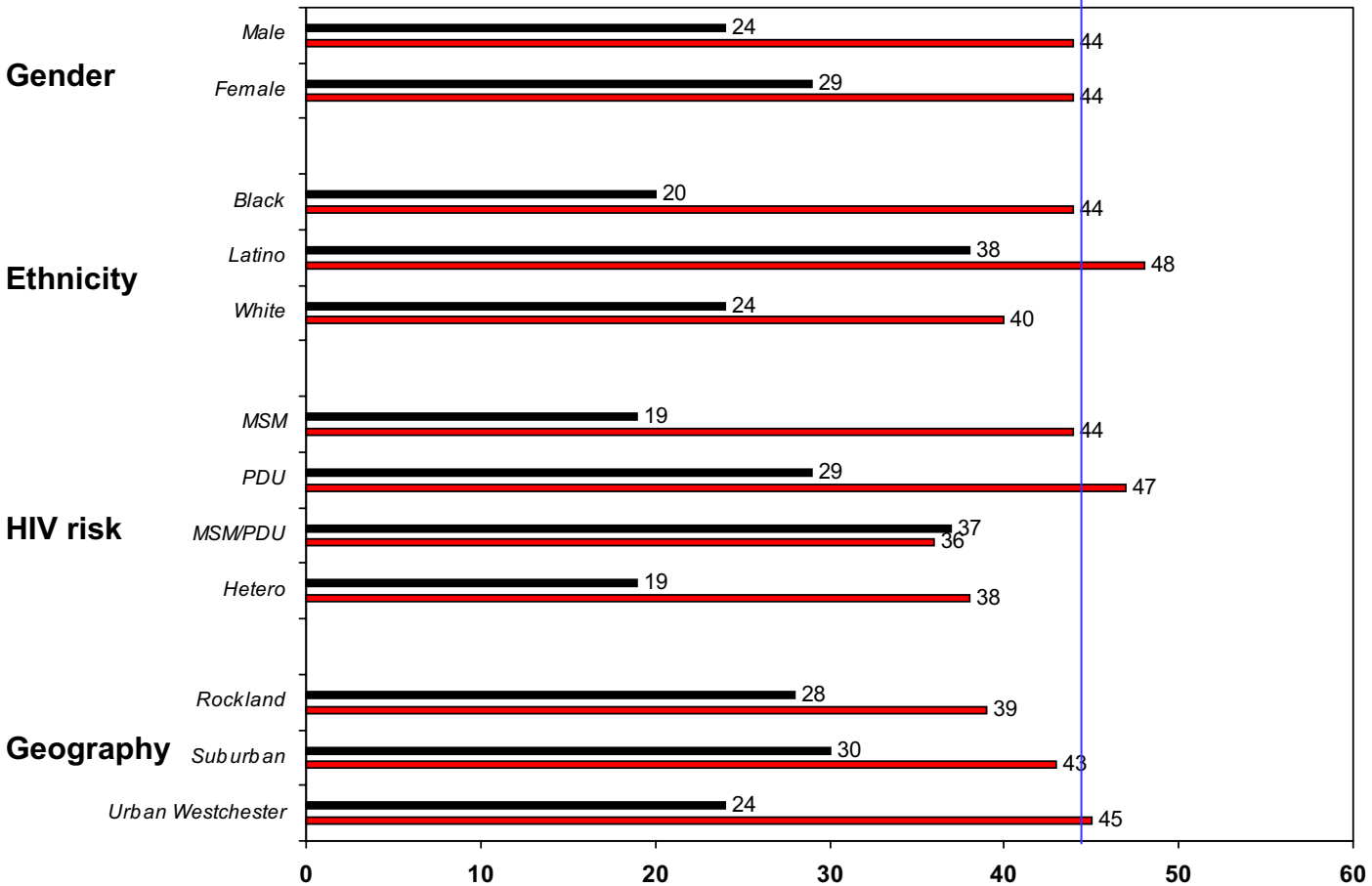
Health care/mental health and other providers will understand AOD culture and provide culturally appropriate and sensitive treatment to AOD users.

**PROGRESS INDICATOR:** Among those who reported current or past drug use, proportion reporting delaying or not getting assistance because of staff insensitivity, perceived misunderstanding, or interpersonal barriers.

Baseline: 26 percent

Wave II\*\*\*: 44 percent

Wave II  
Average



\*\*\*<0.001

 WAVE I data  
 WAVE II data

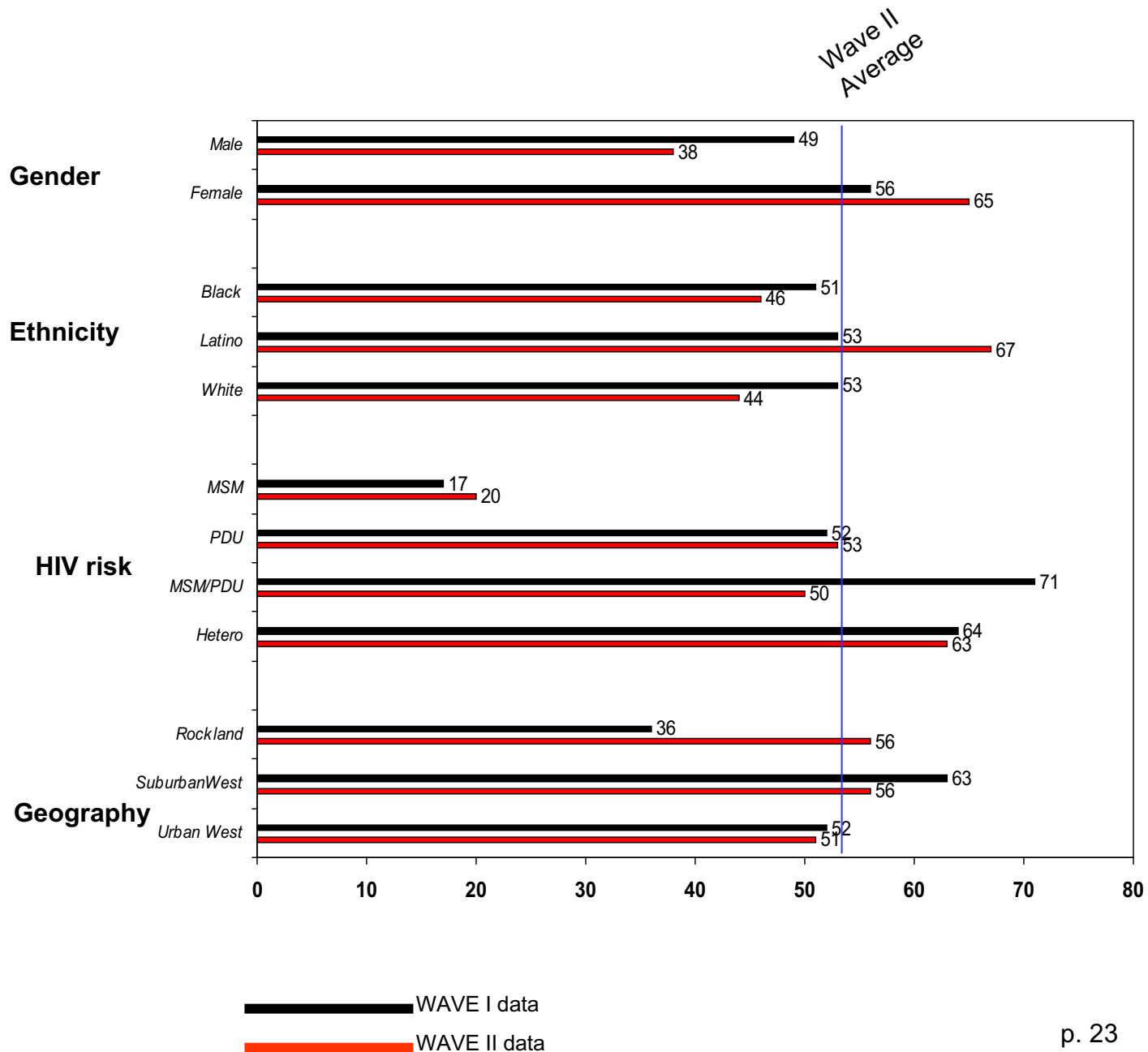
## AOD: Objective 1B

Health care, mental health and other services will be more available and accessible to AOD users.

PROGRESS INDICATOR: Among those who reported current or past drug use and had objective need for mental health services, those who reported that they received professional or supportive mental health services.

Baseline: 53 percent

Wave II: 53 percent



## Social Services: Objective 1B

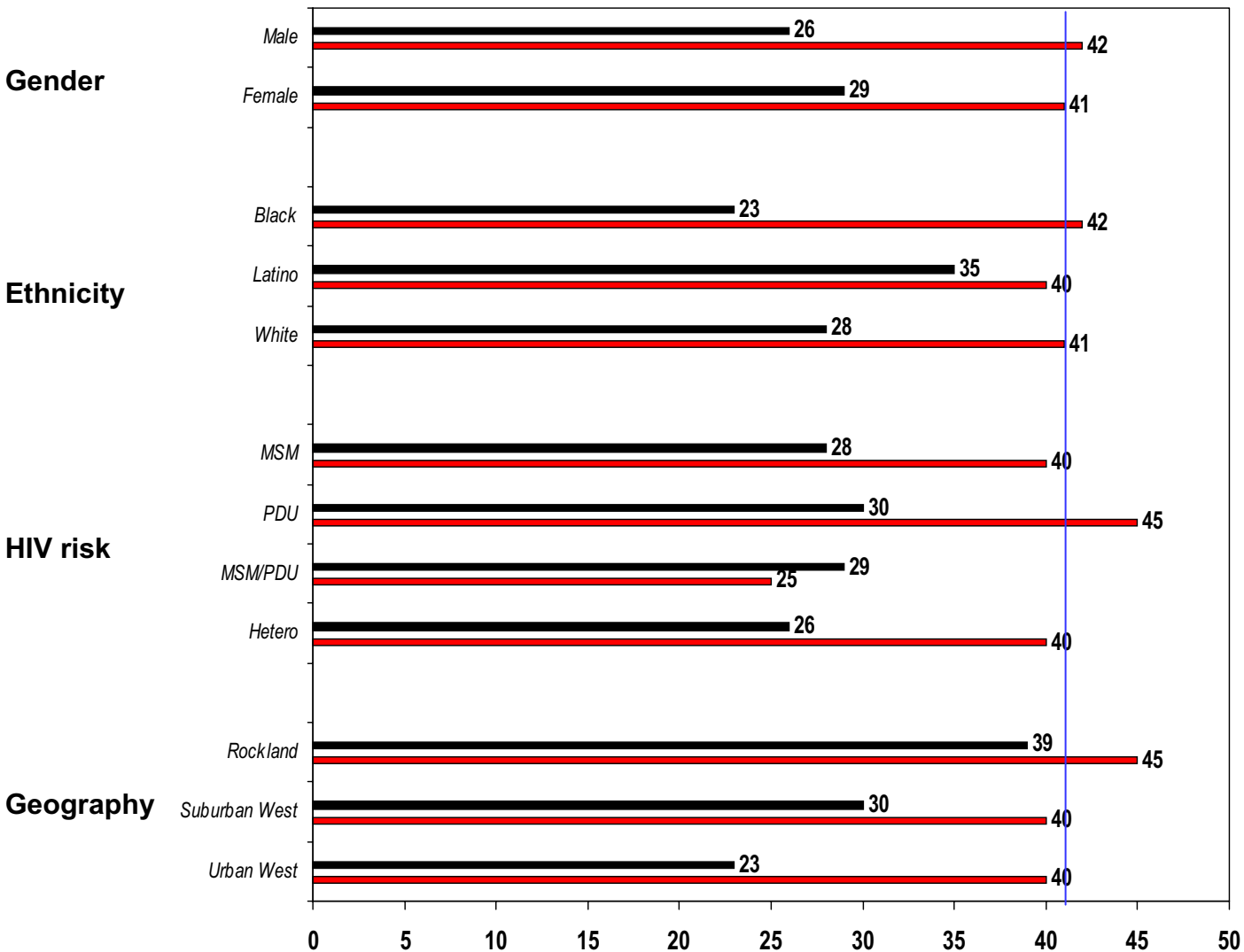
PLWH/A will have access to culturally competent and linguistically appropriate social services

PROGRESS INDICATOR: Proportion reporting delaying or not getting assistance because of language barriers, incompetence, staff insensitivity, perceived misunderstanding, or interpersonal barriers.

Baseline: 28 percent reporting barrier.

Wave II\*\*\*: 41 percent reporting barrier.

Wave II  
Average



\*\*\*<0.001

 Wave I data  
 Wave II data

## Social Services: Objective 1C

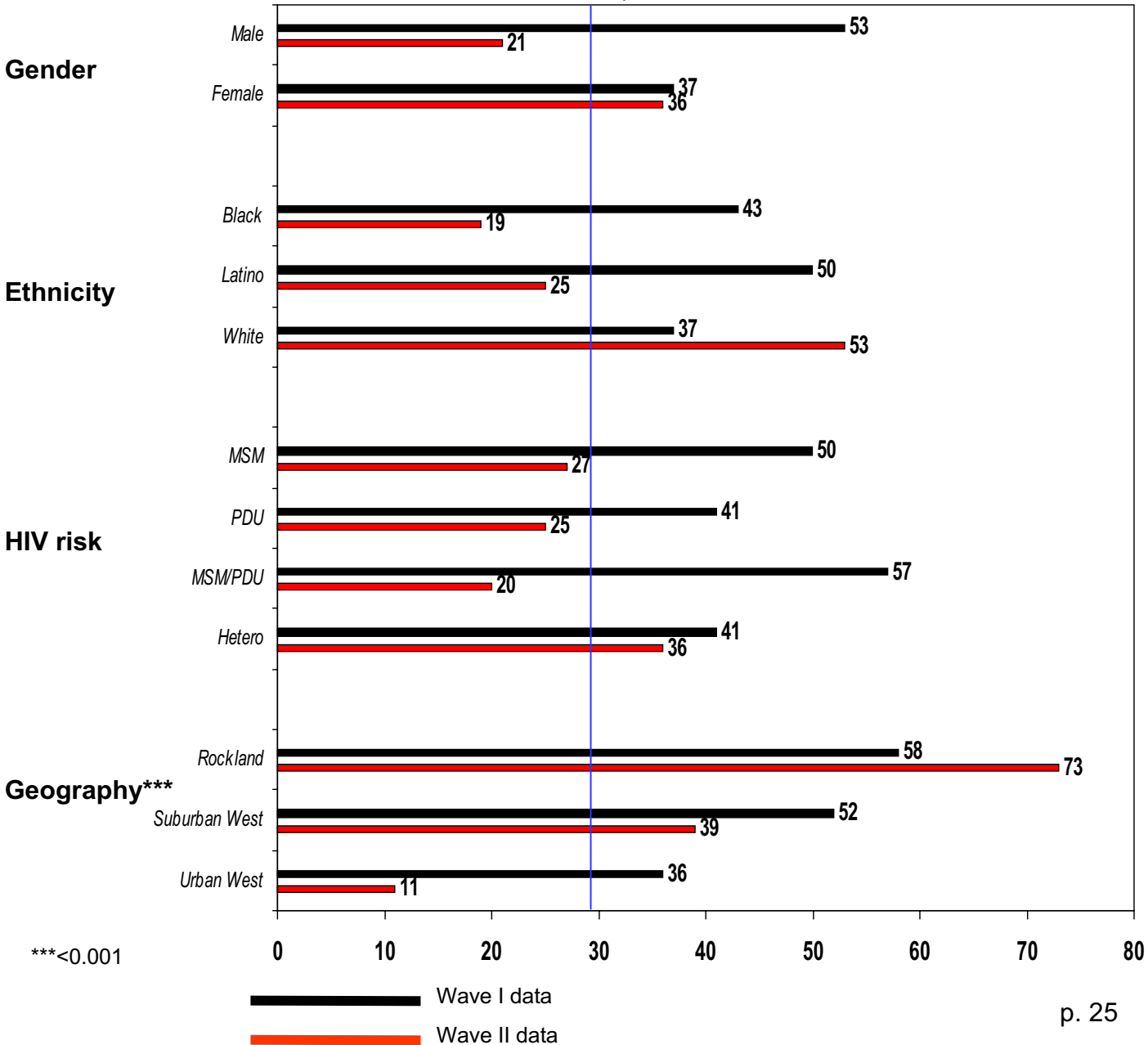
PLWH/A will have access to necessary transportation services.

PROGRESS INDICATOR: Among those who reported needing help with transportation services or that it was a barrier in receiving care in the 6 months prior to interview, those who received transportation services.

Baseline: 43 percent

Wave II: 29 percent

Wave II  
Average



## Social Services: Objective 1D

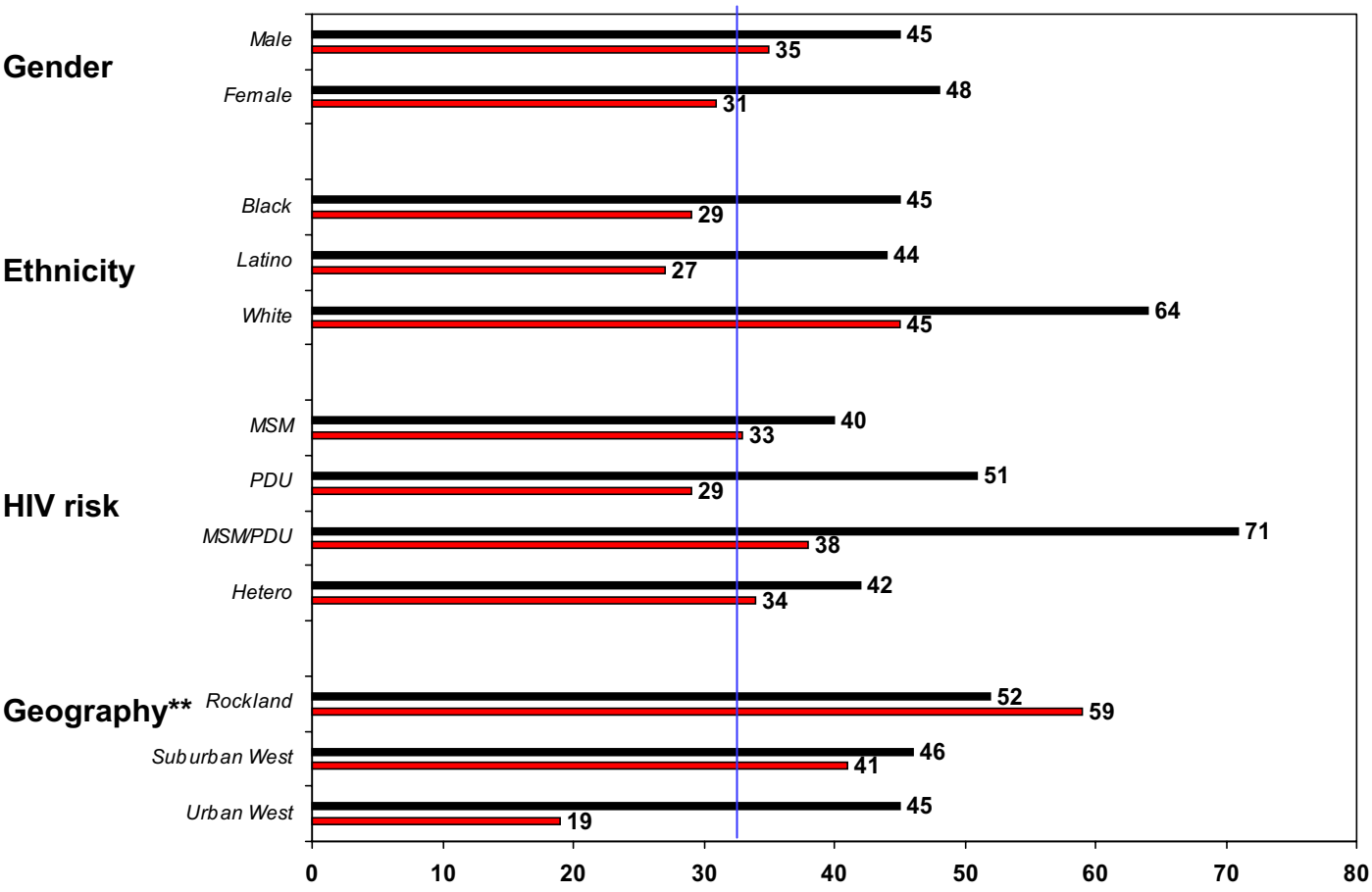
PLWH/A will have access to a broad range of support, advocacy and basic needs programs within their geographic area.

**PROGRESS INDICATOR:** Among those who expressed needing assistance with legal matters, child care, or food/groceries/meals, those who reported that “no change has occurred in the situation or no progress has been made” or that “the problems have been getting worse” in the respective areas.

Baseline: 47 percent

Wave II\*: 32 percent

Wave II  
Average



\*<0.05, \*\*<0.01

Wave I data  
 Wave II data

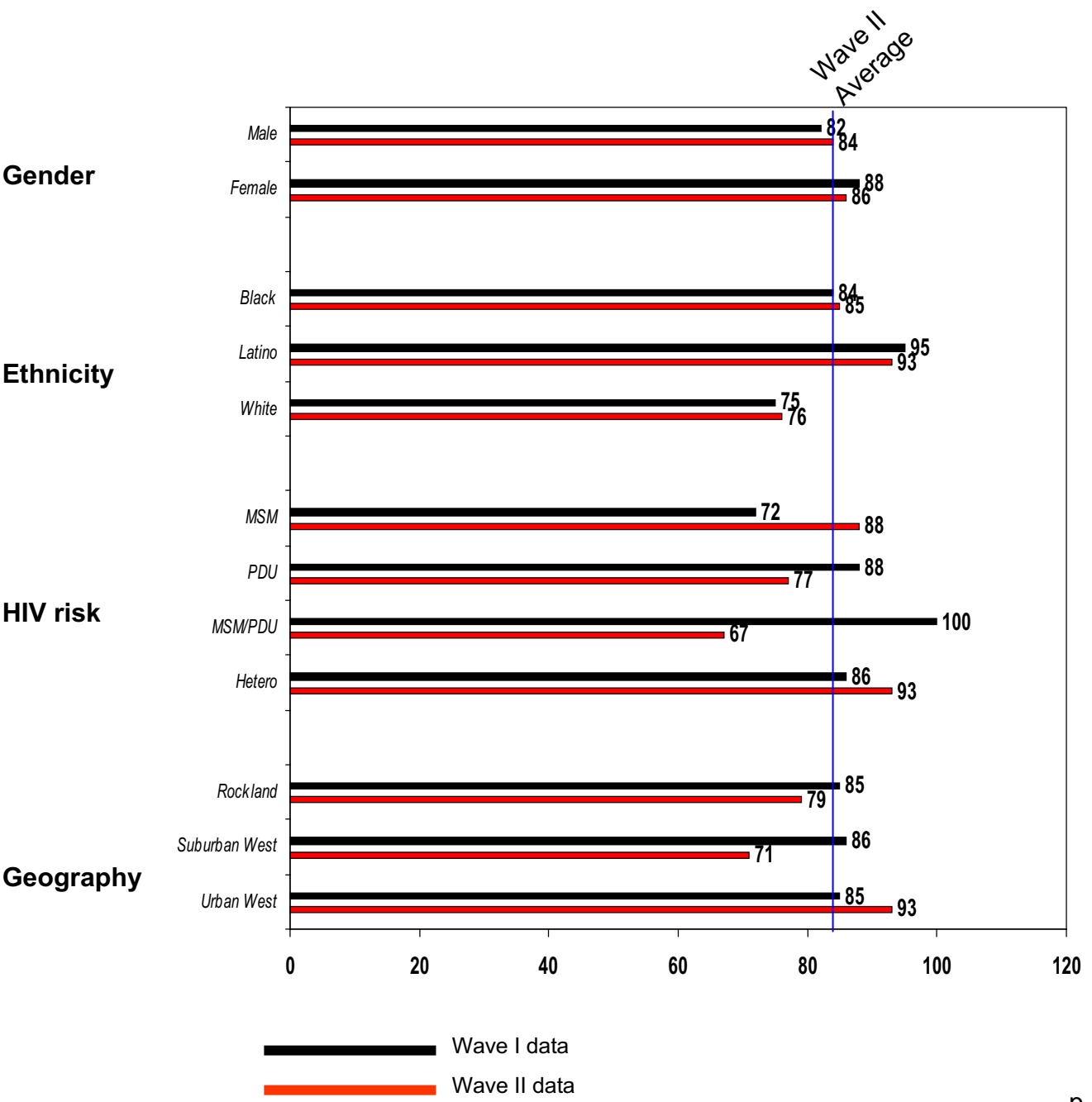
## Social Service: Objective 3B

PLWH/A will have increased knowledge regarding treatment issues and adherence strategies

PROGRESS INDICATOR: Among those who received help with taking medication those who reported that the advice was “very helpful” or “somewhat helpful.”

Baseline: 85 percent

Wave II: 85 percent



## Mental Health: Objective 1B-1

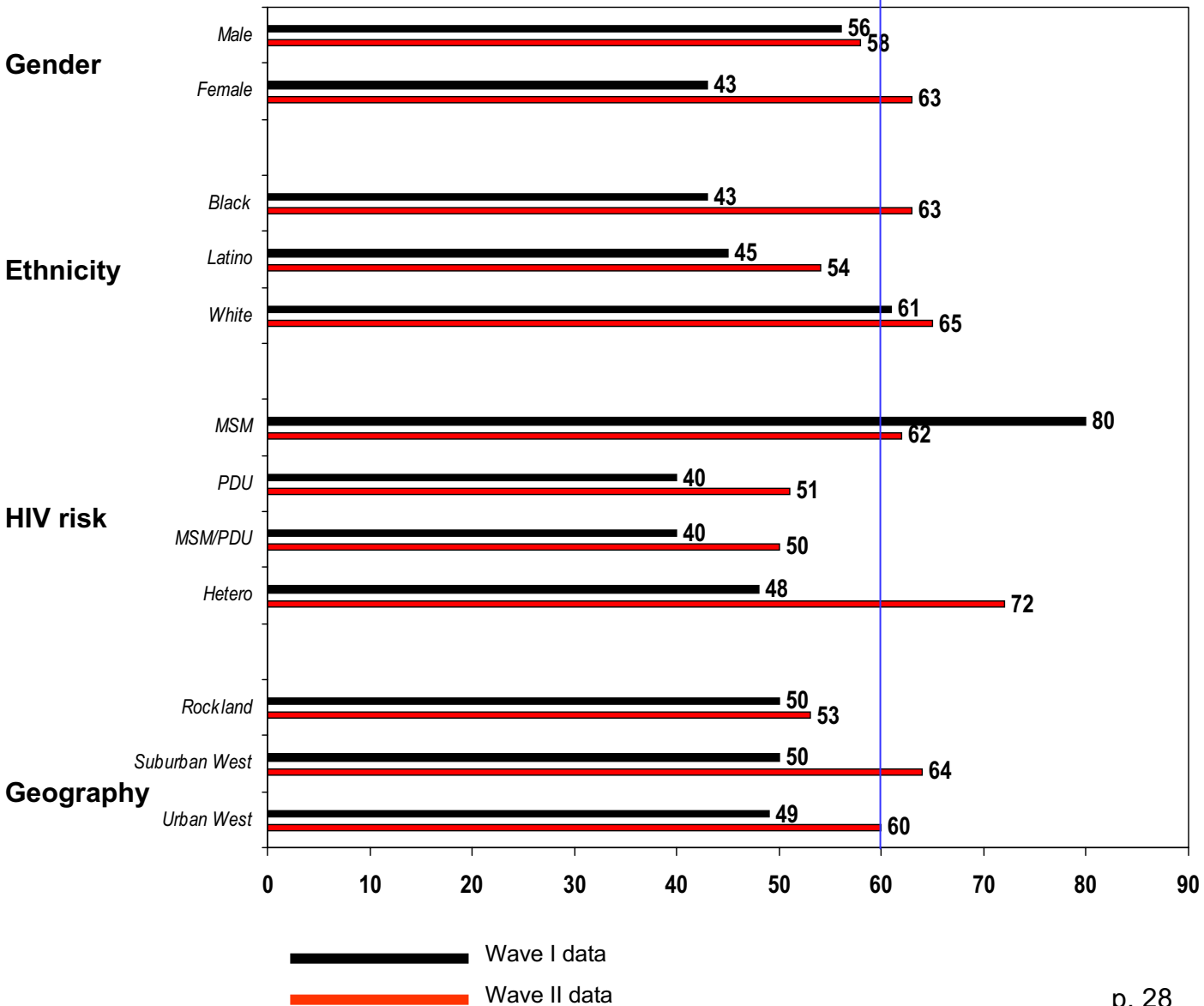
Persons with HIV disease engaged in mental health care and services will adhere to treatment.

**PROGRESS INDICATOR:** Among those who scored very low on standardized mental health scale, those who reported being adherent to HIV medication plus no reported missed pills in the two days prior to interview.

Baseline: 49 percent

Wave II: 60 percent

Wave II  
Average



## Mental Health: Objective 1B-2

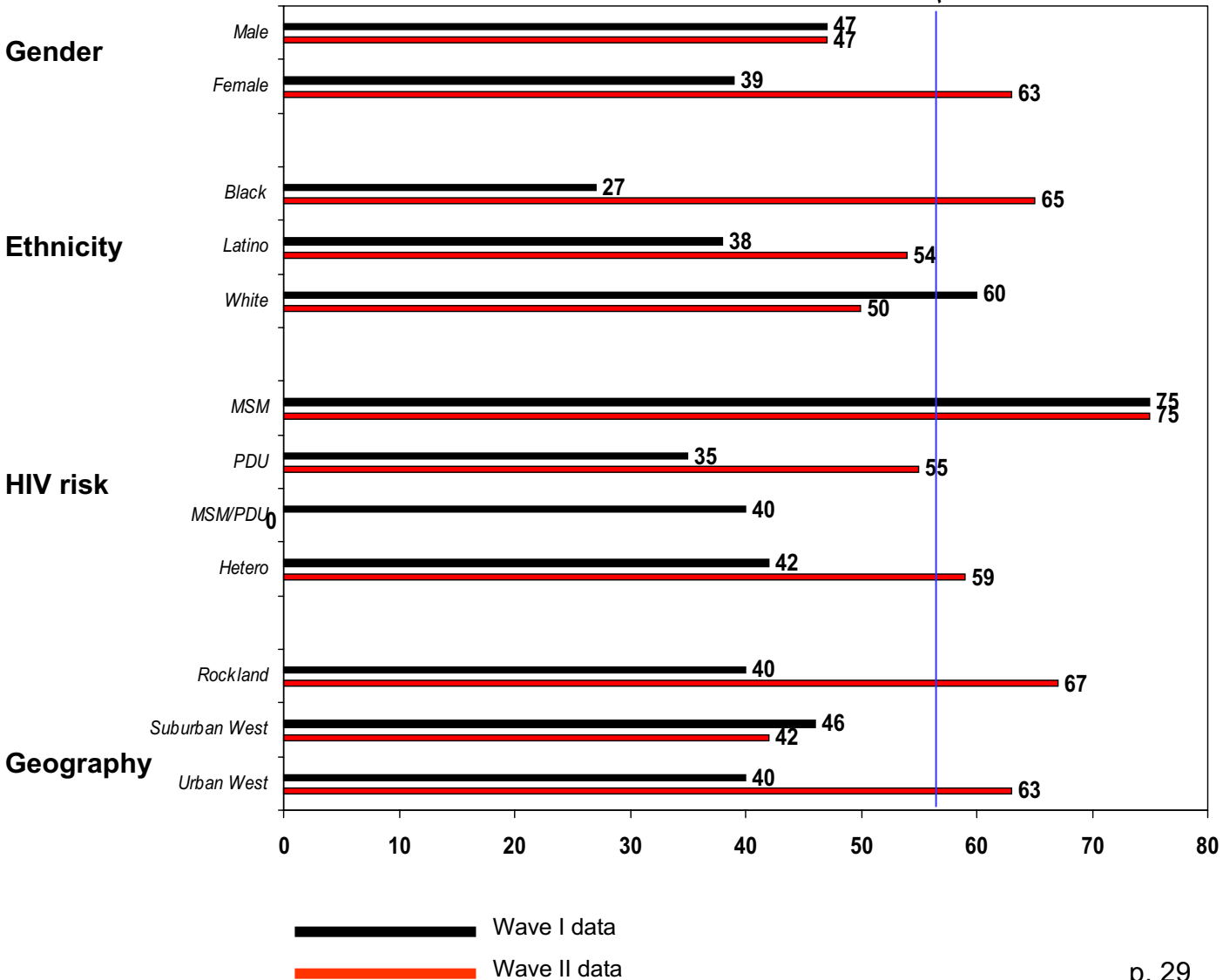
Persons with HIV disease engaged in mental health care and services will adhere to treatment.

**PROGRESS INDICATOR:** Among those who scored very low on standardized mental health scale and reported receiving professional or supportive mental health services, those who self-reported being adherent to HIV medication plus no reported missed pills in the two days prior to interview.

Baseline: 42 percent

Wave II: 57 percent

Wave II  
Average



## Mental Health: Objective 1C-1

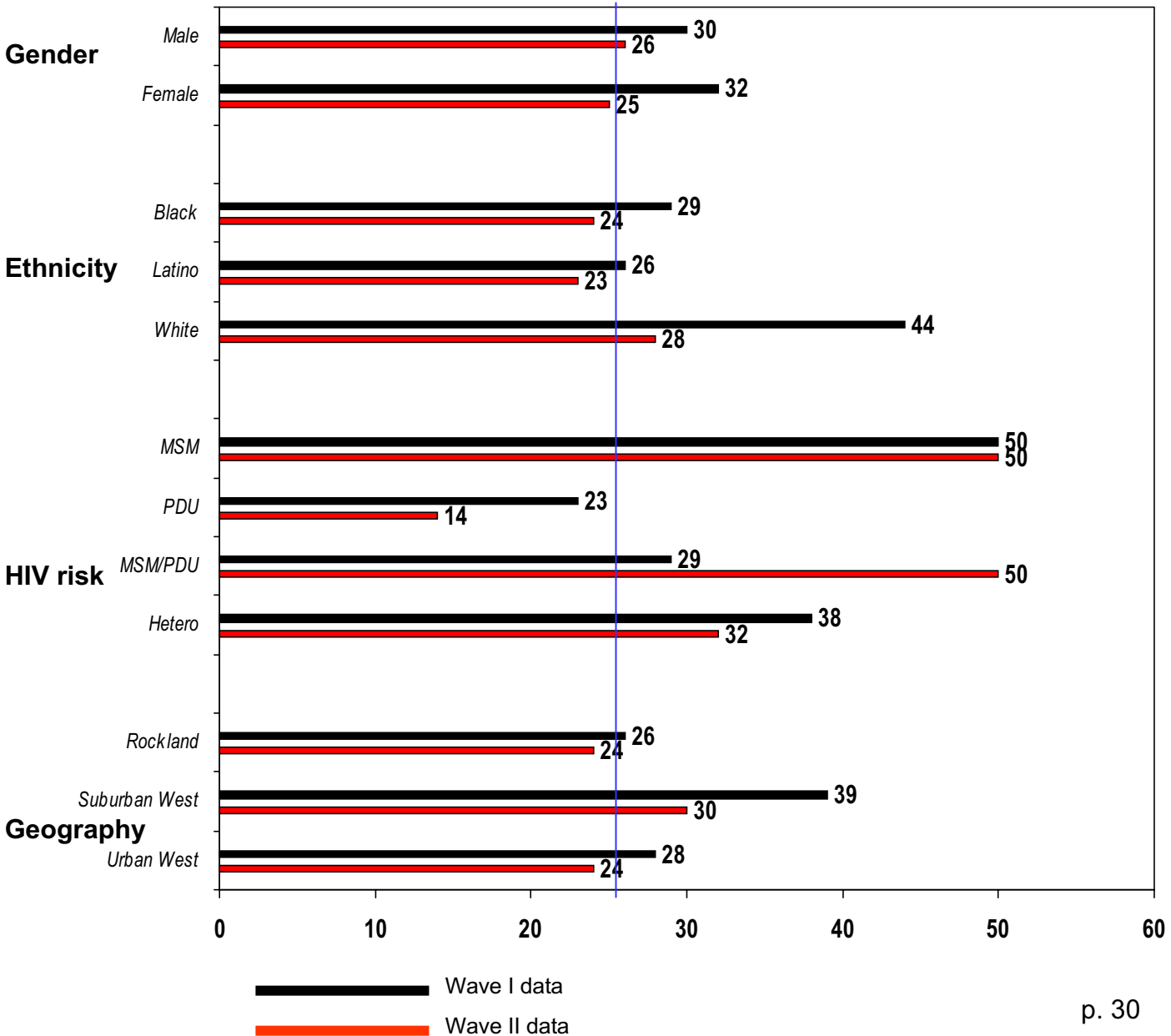
Persons with HIV disease engaged in mental health care and services will have improved quality of life.

PROGRESS INDICATOR: Among those who scored very low on standardized mental health scale, their self-reported health status, as measured by PCS score.

Baseline: 31 percent (PCS scores at or above 45)

Wave II: 25 percent (PCS scores at or above 45)

Wave II  
Average



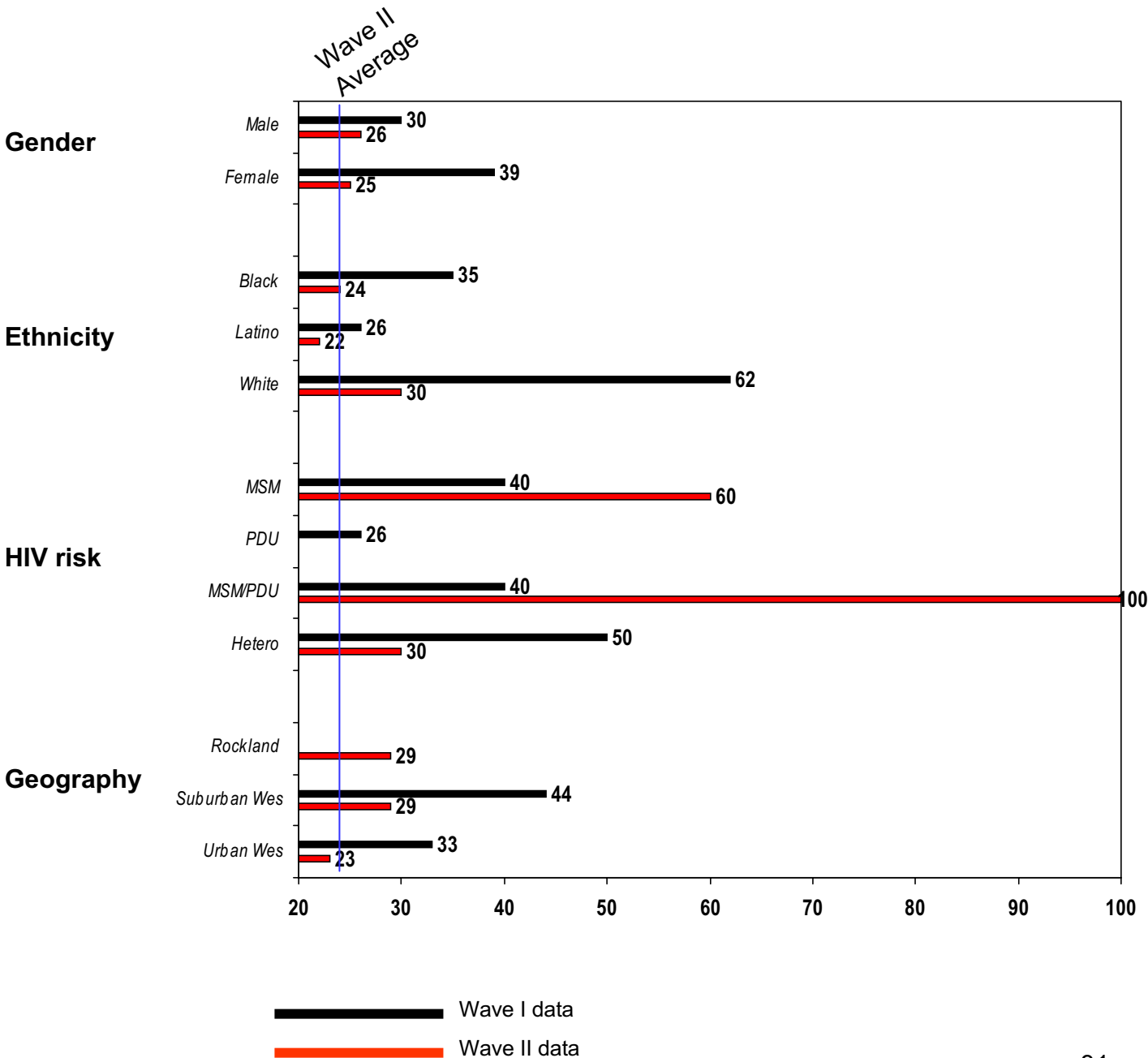
## Mental Health: Objective 1C-2

Persons with HIV disease engaged in mental health care and services will have improved quality of life.

PROGRESS INDICATOR: Among those who scored very low on standardized mental health scale and who reported receiving professional or supportive mental health services, their self-reported health status, as measured by PCS score.

Baseline: 36 percent (PCS scores at or above 45)

Wave II: 25 percent (PCS scores at or above 45)



## Tri-County Objective:

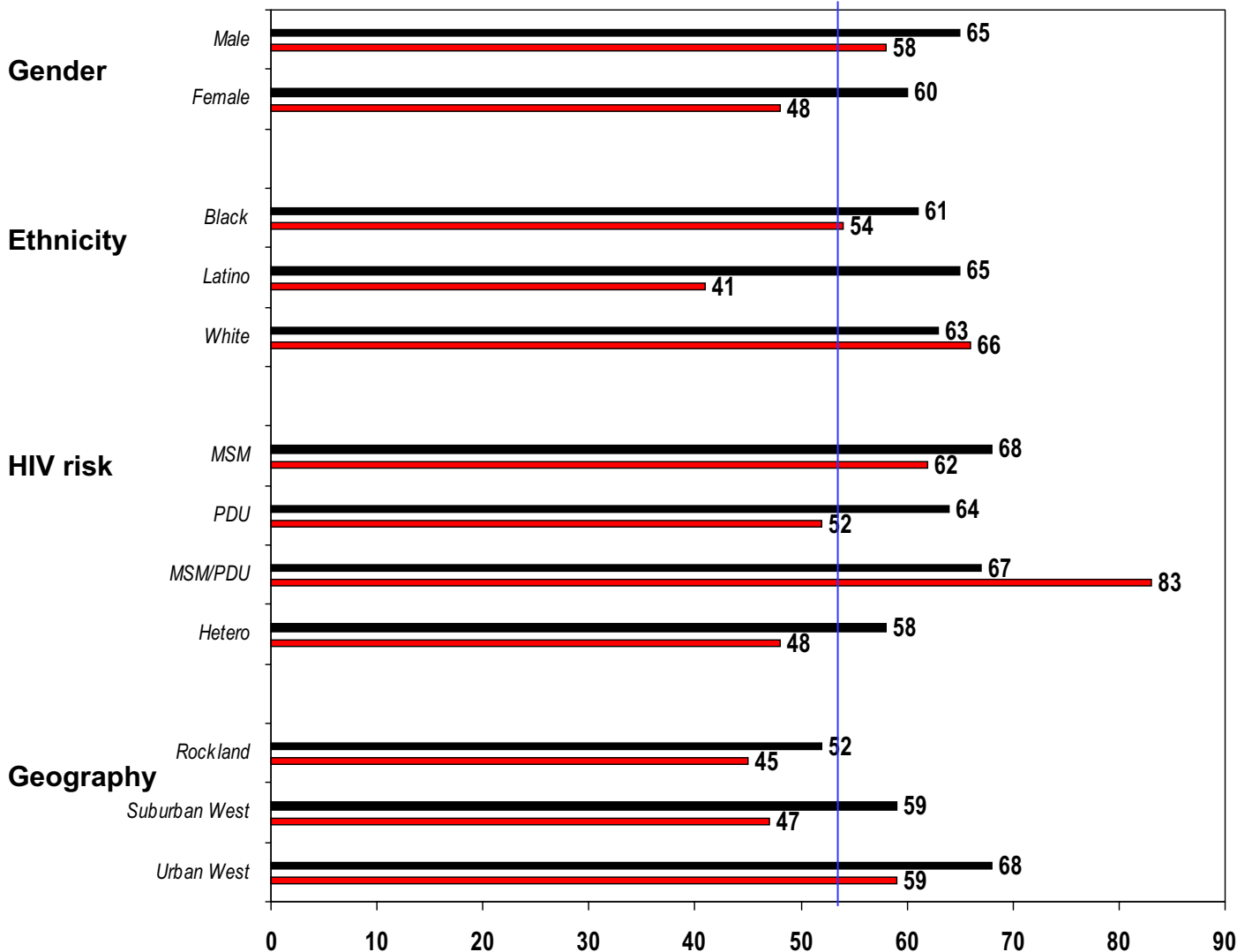
Clients and providers will know what to do to access the services they need.

PROGRESS INDICATOR: Proportion of respondents who say they know where to turn for help for HIV and where to go for services.

Baseline: 63 percent (know how to access needed service)

Wave II\*: 53 percent (know how to access needed service)

Wave II  
Average



\*<0.05

Wave I data  
Wave II data

## Housing: Objective 1A

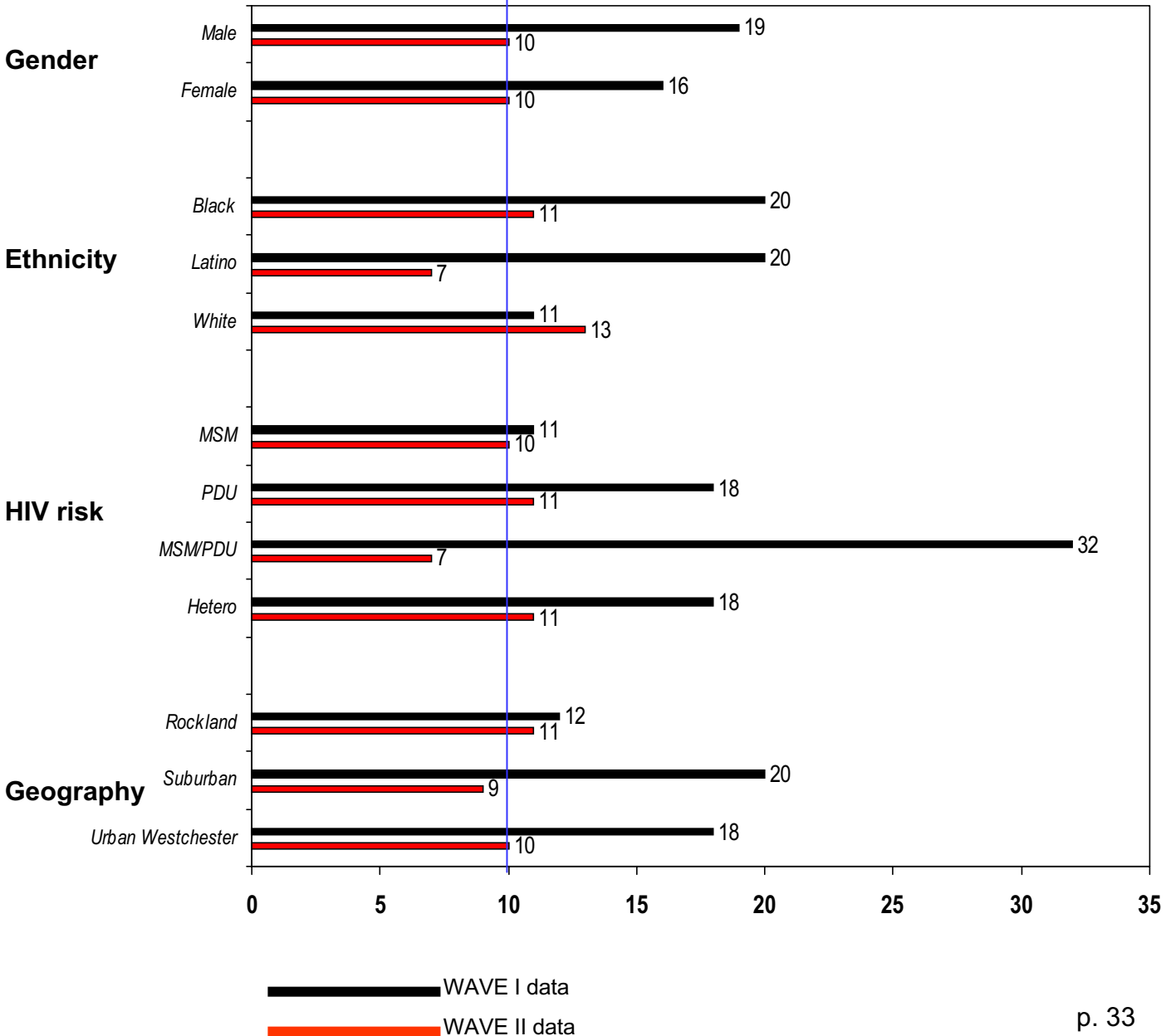
Transitional housing will be available to people with HIV/AIDS who need it.

PROGRESS INDICATOR: Proportion who reported being unstably housed; any episode of living in street, shelter, single room occupancy, or doubled up with a friend or relative.

Baseline: 18 percent

Wave II: 10 percent

Wave II  
Average



## Housing: Objective 2A

Housing placement assistance services will be available for persons with HIV who need them.

**PROGRESS INDICATOR:** Among those who reported being unstably housed, those who received a housing subsidy, lived in specialized AIDS housing (such as scatter-site housing), or received housing services to assist with house/apartment maintenance, landlord/tenant issues, access, etc.

Baseline: 21 percent

Wave II: 15 percent

Wave II  
Average

