

letter from Deputy Mayor



letter from Planning Council Co-Chairs



New York EMA  
**Comprehensive  
Strategic Plan**  
for **HIV/AIDS Services**

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2002 - 2005



**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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# Executive Summary

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*The Comprehensive Strategic Plan for HIV/AIDS Services 2002-2005* addresses health and human services for people with HIV disease in the New York eligible metropolitan area (EMA). It can be used by anyone involved in planning, funding, delivering, receiving, or measuring the effectiveness of HIV services. The plan includes goals, objectives, and a monitoring and evaluation framework. The vision of the plan is that people living with HIV disease in the New York EMA will have access to appropriate, quality services across the continuum of care, resulting in the best possible health and quality of life.

The plan covers the five New York City boroughs of Brooklyn, the Bronx, Manhattan, Queens, and Staten Island as well as the three Lower Hudson Valley counties (referred to as Tri-County) of Westchester, Putnam, and Rockland, which are part of the Federal eligible metropolitan area for CARE Act Title I funding.

## Who prepared the plan?

The HIV Health and Human Services Planning Council of New York and its member groups prepared this plan. The Planning Council was established in 1990 to meet a legislative mandate of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. The CARE Act provides Federal funds that are used to develop systems of care and to pay for medical and social support services for people living with HIV disease and their families. New York City receives a variety of CARE Act funds, including Title I funds. In 2002, the Title I grant for the New York EMA was \$117.7 million.

Using a community-based, data-driven process that started in 2001, the Planning and Evaluation Committee of the Planning Council mobilized Work Groups, the Tri-County Steering Committee, staff, consultants, and others to develop and prepare this plan.

In addition to helping New York City pursue its vision for New Yorkers with HIV disease, the plan satisfies the CARE Act requirement that Planning Councils develop a comprehensive plan for the organization and delivery of health services that is compatible with any existing State or local plan regarding the provision of health services to individuals with HIV disease.

The plan covers the period between September 2002 and August 2005. The Planning Council will review the plan once a year, and updates may be issued. In addition, the Planning and Evaluation Committee will develop annual implementation plans.

## How is the plan organized?

The plan consists of three chapters and four appendices. Chapter 1 deals with the question, “Where Are We Now?” It provides an overview of the HIV/AIDS epidemic in New York City and the Tri-County region, including background, service needs, resources, and service gaps. This chapter is adapted from the *Initial Needs Assessment for New York City 2002*, the *Initial Needs Assessment for the Tri-County Region 2002*, and additional materials.

Chapter 2 addresses the question, “Where Are We Going?” The chapter starts with a review of the planning principles that were used to develop this plan. It also includes the plan’s core goals and objectives, and action steps.

Chapter 3 focuses on “How Will We Monitor Our Progress?” It presents a framework that includes indicators and measures for monitoring and evaluation of the plan’s objectives.

Appendix A presents a glossary of terms and acronyms. Appendix B is a list of the source materials used by the Planning Council, its Work Groups, staff, and consultants in developing the plan. Appendix C shows six maps of CARE Act-funded service sites in New York City. Appendix D assesses service gaps and unmet needs that the Planning Council used with other data to develop goals and objectives.

## What are the key facts found in the plan?

The AIDS epidemic in the New York EMA reflects the racial, ethnic, cultural, and economic diversity of its general population. Key facts include:

- Between 1981 and late 2001, over 126,000 AIDS cases have been reported in New York City. As of June 2000, a total of 5,055 cumulative adult and adolescent AIDS cases had been diagnosed in the Tri-County region.
- The incidence of AIDS in New York City is dramatically higher than in the rest of the country.
- Each of New York City’s five boroughs and three Tri-County region counties has experienced the AIDS epidemic in unique ways.
- Approximately 73 percent of all persons diagnosed with AIDS in New York City from 1981 through late 2001 have been Blacks and Hispanics.

- An estimated 120,000 people in New York City and an additional 6,000 people in the Tri-County region are living with HIV disease. This includes people with reported HIV, people living with AIDS, and people who are undiagnosed/unreported.
- HIV surveillance data estimates 7,800 new HIV diagnoses per year citywide.
- An HIV-positive New Yorker is likely to be affected by one or more other diseases or conditions, such as active substance use, sexually transmitted diseases, homelessness, mental illness, or tuberculosis.
- In 1995, the number of deaths of adults and adolescents per year in New York City peaked at 7,855. By 2001, that number had declined to 1,080.
- A variety of factors can be credited for the drop in AIDS deaths. This includes earlier identification of HIV infection, access to treatment for HIV disease, the availability of new antiretroviral drugs, and the efficacy of prophylaxis for opportunistic infections that preceded the widespread adoption of combination therapies.

Broad themes and general trends gleaned from the *Initial Needs Assessment for New York City 2002* can be stated as a basic framework for readers of this document as follows:

In New York City:

- Persons with HIV/AIDS who seek care and services can get them in New York City.
- Affordable and medically appropriate housing is the most 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.

In the Tri-County region:

- As is the case across many other counties in New York State, the Tri-County epidemic continues to disproportionately affect communities of color.
- The wide geographic distribution of specific populations in the Tri-County region, combined with a limited number of HIV/AIDS service providers, restricts the number of specialized programs that are funded.
- Affordable housing, accessible substance abuse treatment/harm reduction programs, and transportation are some of the most pressing unmet needs in the Tri-County region.



## Guide to Readers

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This section prepares readers to use this plan effectively. Each reader will have a different reason for using this document. Key audiences are people living with HIV disease in New York; the HIV Health and Human Services Planning Council of New York; the Tri-County Title I Steering Committee; and the HIV/AIDS Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services, and the New York State Department of Health. Elected leaders represent another important audience, including the Mayor, Borough Presidents, and members of the City Council. Other audiences include: City agencies, community-based organizations (including service providers), hospitals, other planning authorities and decision-makers, the public (through the media and directly), and advocacy groups. The plan can also be viewed at the Planning Council's website, at [www.nyplanningcouncil.org](http://www.nyplanningcouncil.org). Every effort has been made to provide a plan that is readable and accessible to all these audiences.

Representatives from many of these groups assisted in the development of this plan. However, the goals and objectives and the framework for measuring progress contained here reflect decisions of the HIV Health and Human Services Planning Council of New York.

The Ryan White Comprehensive AIDS Resources Emergency Act (usually called "the Ryan White CARE Act" or sometimes simply "the CARE Act") is a Federal law that was first passed by Congress in 1990. In 2000, the CARE Act was reauthorized through 2005 with new requirements (Public Law 106-345). The CARE Act provides Federal funds that are used to develop systems of care and to pay for medical and social support services for people living with HIV disease and their families. The CARE Act identifies who can receive this money and describes how the money can be used. Title I of the CARE Act provides emergency assistance to eligible metropolitan areas, including New York City. The CARE Act requires Title I cities to establish a Planning Council.

This document satisfies the requirement of the CARE Act that each Title I Planning Council develop a comprehensive plan for the organization and delivery of health services for people with HIV disease. This plan will guide future Title I Planning Council decision-making in New York City and the Tri-County region for the period 2002 to 2005. The plan will be revisited annually and modified as necessary. Other agencies responsible for various aspects of HIV/AIDS services planning, delivery, or funding are expected to use this plan in their own processes.

## Duties of the Planning Council

Summarized from CARE Act Amendments of 2000.

- 1) Determine the size and demographics of the population of individuals with HIV disease within the EMA.
- 2) Determine the needs of the HIV population, focusing on a) individuals who know their status but are not in care, and b) disparities among historically underserved subpopulations.
- 3) Establish funding priorities that take into consideration: both (1) and (2) above, potential cost and outcome effectiveness of the proposed services, the priorities of the HIV infected population, the availability of other governmental and non-governmental funding sources, and capacity development needs resulting from disparities in HIV-related services in historically underserved communities.
- 4) Develop a comprehensive plan for the organization and delivery of health and support services.
- 5) Assess the efficiency of the Planning Council's administrative mechanism in rapidly allocating funds to areas of greatest need within the EMA and of the services offered in meeting identified needs.
- 6) Participate in the development of the statewide coordinated statement of need initiated by the State public health agency.
- 7) Establish methods for obtaining input on community needs and priorities, which may include public meetings, conducting focus groups, and convening ad-hoc panels.
- 8) Coordinate with Federal grantees that provide HIV-related services within the eligible area.

The duty related to the development of a comprehensive plan is discussed in more detail in Chapter 2.

This document represents one of many past, current, and ongoing HIV service planning activities in New York City. It incorporates previous plans and planning reports produced under the auspices of the Planning Council, as well as reports on funded services, a major ongoing survey of people living with HIV disease in New York City, community input activities, funding applications to the Federal government, State of New York Department of Health AIDS Institute documents and data, and epidemiologic data. Readers are urged to keep in mind that HIV services planning is an ongoing process. Therefore, new information is continuously available and will be included in all future planning efforts.

## Key Facts

This plan addresses health and human services for people with HIV disease in New York City and the three Lower Hudson Valley counties of Westchester, Putnam, and Rockland.

The plan is a major product of the HIV Health and Human Services Planning Council of New York, which used a community-based, evidence-based process to develop it.

The actions in the plan are to occur between September 2002 and August 2005.

The plan can be used by anyone involved in planning, funding, delivering, receiving, or measuring the effectiveness of HIV services.

The plan shows how to monitor and evaluate progress so that changes to the plan can be made accordingly. It will be reviewed once a year by the Planning Council, which may choose to issue periodic updates.

## Topics not included in the plan

Planning issues directly related to HIV prevention and Housing Opportunities for People with AIDS (HOPWA) are not included.

Readers interested in HIV prevention planning are referred to the New York City HIV Prevention Plan.

Those readers interested in HOPWA are referred to the U.S. Department of Housing and Urban Development Formula Grant Consolidated Plan for New York City. Go to: [www.nyc.gov/html/dcp/html/pub/conpln02.html](http://www.nyc.gov/html/dcp/html/pub/conpln02.html)

Readers seeking more information about a particular topic or new information that becomes available from future HIV planning processes are encouraged to contact the Planning Council.

## Use of “HIV disease”

This document generally uses the term “HIV disease” to describe the entire spectrum of the natural history of the virus, from infection to the clinical definition of AIDS. The acronym “PLWA” refers to people living with AIDS.



# The HIV/AIDS Epidemic in New York: Where Are We Now?

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Chapter 1 provides an overview of the HIV/AIDS epidemic in New York City and the Tri-County region. This chapter is a summary and update of material included in the *Initial Needs Assessment for New York City 2002* and the *Initial Needs Assessment for the Tri-County Region 2002*. The chapter focuses on background information and needs, current services and available resources, and services gaps. To fully understand the material presented, the reader is encouraged to reference tables and figures included in both needs assessment documents. In this chapter, New York City is presented first. Tri-County information follows in a separate section. A discussion of EMA-wide data gaps appears below.

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 needs assessment objective is to ensure 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.

The needs assessments for the New York EMA were commissioned by the HIV Health and Human Services Planning Council of New York. They partially satisfy the mandates of the CARE Act Amendments of 2000, which require each Title I planning council to assess needs and develop comprehensive plans for the organization and delivery of HIV/AIDS services.

The needs assessments for New York City and the Tri-County region are consistent with the CARE Act Amendments of 2000, Federal guidance as promulgated by the Health Resources and Services Administration (HRSA), and local circumstances. Major elements are:

- An epidemiological profile describing the current status of the epidemic, 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.

- 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 people living with HIV disease.
- An assessment of gaps in services that brings together data on service needs, resources, and barriers to help set priorities and allocate resources.

This section presents a separate epidemiological profile for New York City. It is based on data sources presented in the *Initial Needs Assessment for New York City 2002*. It portrays the epidemic as it currently exists and describes those disproportionately affected. It also highlights important changes, including disease demographics over the past decade. Finally, it tracks emerging trends that will likely shape the epidemic over the coming years.

## EMA-Wide Data Gaps

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.

The needs assessment discusses the use of data for these purposes. It also addresses data availability and data gaps in the New York EMA as well as HRSA program evaluation requirements.

Many of the source documents used in the *Initial Needs Assessment* 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 can not be generalized beyond the relatively few clients as providers 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, the information can be generalized. Thus, quantitative data is more appropriate for assessing program gaps, for decisions regarding resource prioritization, and for definitively stating that desired outcomes have been achieved.

The New York EMA has an excellent resource of quantitative data available in the form of its ongoing CHAIN (Community Health Advisory Information Network) study, which has followed a cohort of people living with HIV/AIDS in New York City since the mid 1990s (conducting structured interviews approximately once a year). CHAIN update reports, frequently cited throughout the *Initial Needs Assessment* and this plan, along with HIV/AIDS surveillance data, provide the primary sources of quantitative data available to the Planning Council. As of 2002, a cohort of people living with HIV disease from the Tri-County region will be included in the CHAIN study. The New York City CHAIN cohort will be refreshed in 2002. In addition, the New York EMA has drawn upon studies undertaken by the New York Academy of Medicine that evaluate the efficacy of certain programs funded under the Minority AIDS Initiative (MAI).

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 lack 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.

## A. New York City Needs Assessment

The New York City initial needs assessment compiles both qualitative and quantitative data from a wide range of existing sources. Nearly 130 documents were gathered and thousands of pages analyzed. Refer to Appendix B of this plan for a listing of the documents used in the initial needs assessment.

Table 1 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% (to 8,008,278), 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). Race/ethnicity changes at the borough level generally mirrored those of the City as a whole.

As of December 31, 2001, a total of 126,130 cumulative adult and adolescent AIDS cases had been diagnosed in New York City. Of these, 48,145 people were known to be living with the disease at the end of 2001, the most recent year in which these data were publicly available.

The largest proportion of AIDS cases results from injection drug use – 44% of cumulative cases.

**Table 1. Race/Borough Populations and Sub-populations in 2000 Compared to 1990**

Category	Number	Percent	Percent Change Since 1990
A	B	C	D
<b>New York City</b>	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
<b>Brooklyn</b>	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
<b>Bronx</b>	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
<b>Manhattan</b>	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
<b>Queens</b>	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
<b>Staten Island</b>	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 1** *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

The disease disproportionately affects:

- Males – approximately 76% of cumulative cases and 73% of living cases.
- Blacks and Hispanics – approximately 73% of cumulative cases and 77% of living cases.
- Manhattan residents – approximately 35% of cumulative cases and 33% of living cases.

Observations in the last several years reveal potentially critical changes in disease demographics. These changes are:

- The proportion of AIDS cases diagnosed among women in a given year has increased from 23% in 1992 to 32% in 2001.
- The proportion of AIDS cases diagnosed among Blacks and Hispanics in a given year has increased from 74% in 1992 to 84% in 2001.
- 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.

Recent 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 MSM (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.

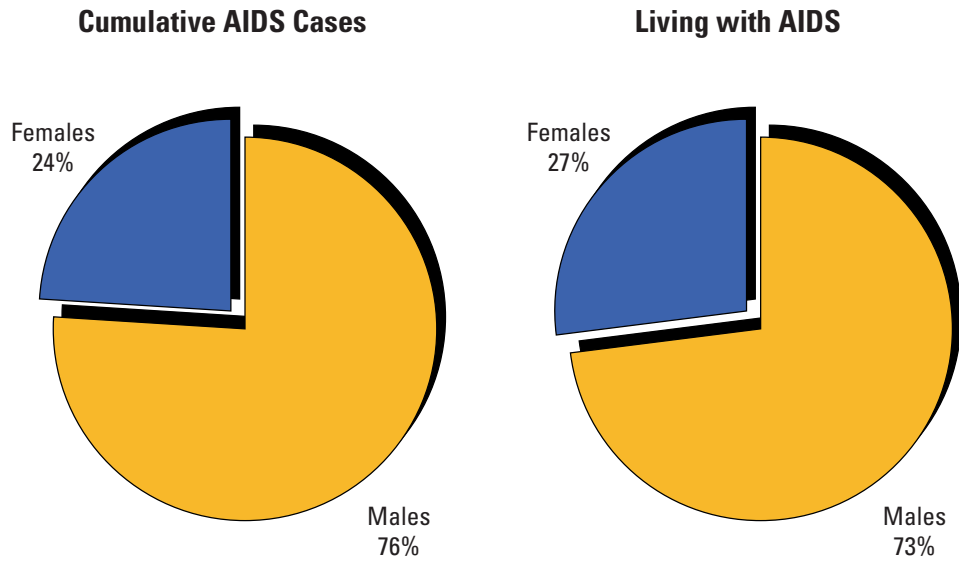
As of December 31, 2001, 2,011 cumulative pediatric AIDS cases had been diagnosed in New York City. Of these, 738 children were still known to be living with the disease at the end of 2001, the most recent year in which these data were publicly available. The vast majority of these are Black and Hispanic children – 91% of cumulative cases. A total of 47% of cumulative pediatric AIDS cases were children who were infected from IDU (injection drug user) mothers.

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 1995 the number of adult/adolescent AIDS deaths per year peaked at 7,855. By 2001 that number had declined to 1,080.

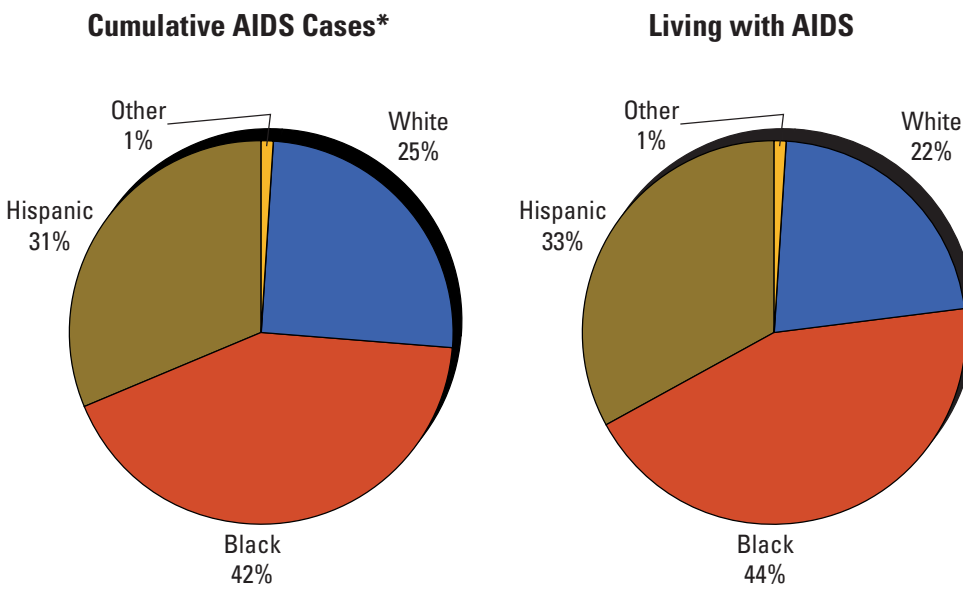
Simultaneously, advancements in pre- and post-natal HIV treatment have led to a major reduction in pediatric HIV/AIDS cases. The rate of vertical HIV transmission from mother to child in New York State is reported to have decreased dramatically—from 25% to 3.5%—since the implementation of a 1997 law requiring infant HIV testing and maternal notification. In fact, during 2001, only 38 new AIDS cases among children were reported.

Figures 1-14 graphically depict the preceding information.

**Figure 1. Adult/adolescent AIDS cases in New York City, cumulative and living by gender, 2001**

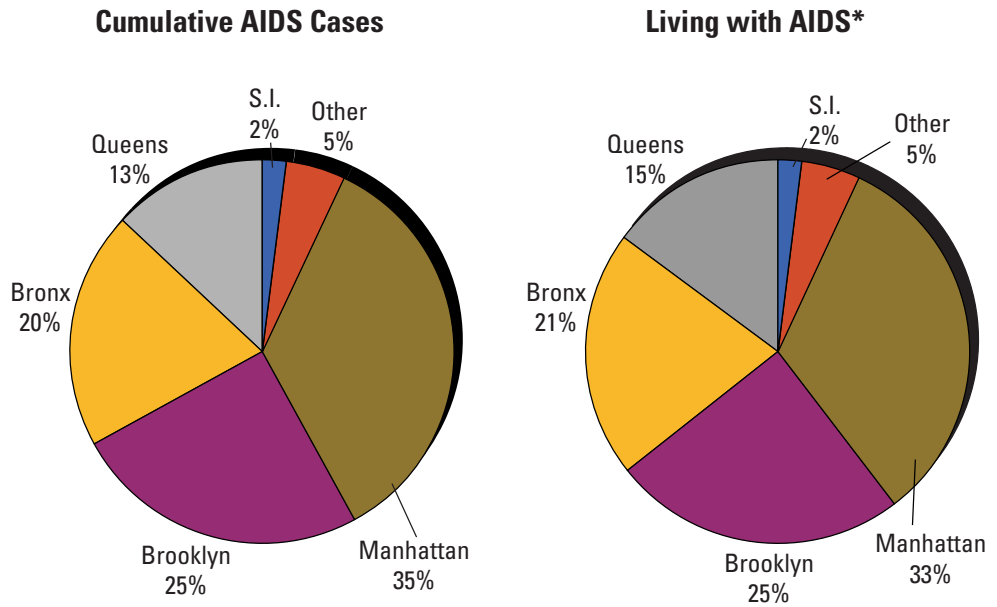


**Figure 2. Adult/adolescent AIDS cases in New York City, cumulative and living by race/ethnicity, 2001**

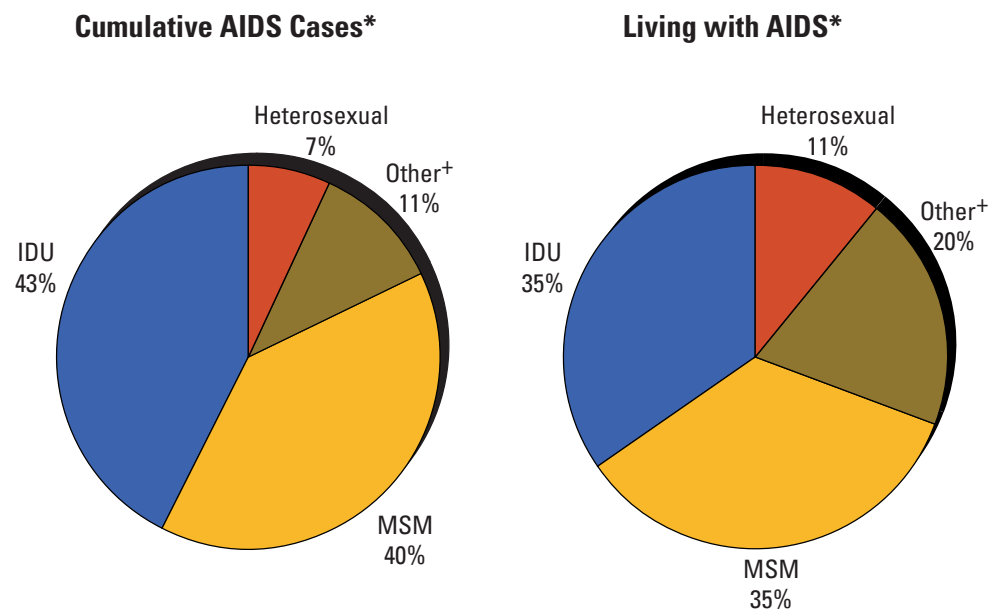


\* Does not total 100% due to rounding.

**Figure 3. Adult/adolescent AIDS cases in New York City, cumulative and living by borough, 2001**

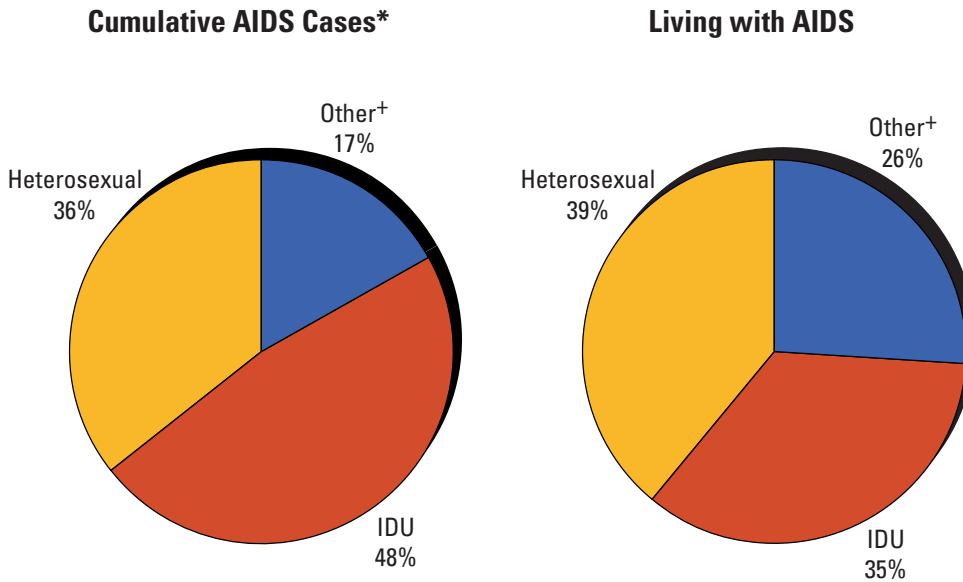


**Figure 4. Male adult/adolescent AIDS cases in New York City, cumulative and living by mode of transmission, 2001**

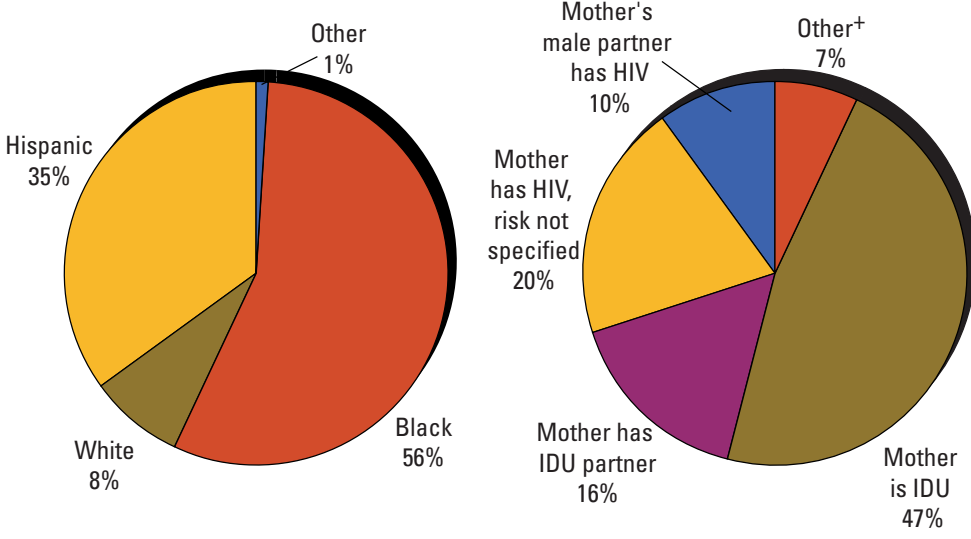


\* Does not total 100% due to rounding.  
<sup>+</sup> Including cases under investigation.

**Figure 5. Female adult/adolescent AIDS cases in New York City, cumulative and living by mode of transmission, 2001**



**Figure 6. Cumulative pediatric<sup>2</sup> AIDS cases in New York City**  
**Cumulative AIDS Cases, Through 2001**      **Cumulative AIDS Cases, Through 2000**

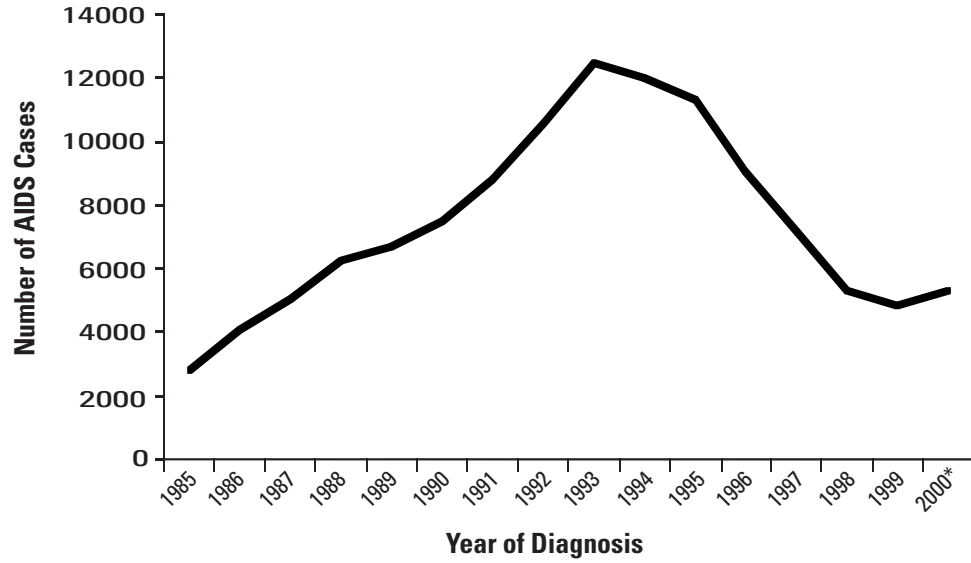


\* Does not total 100% due to rounding.

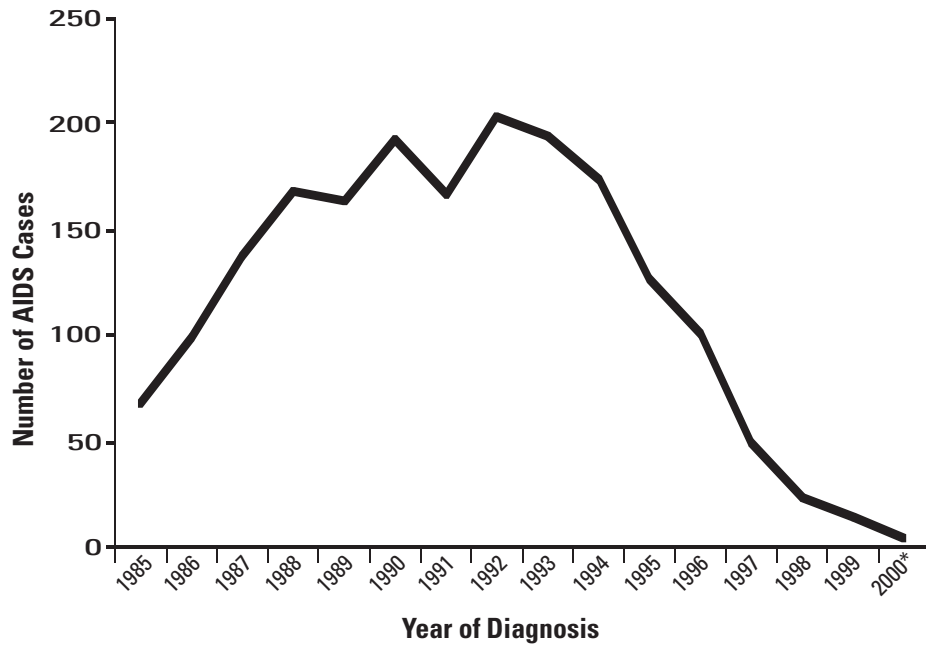
<sup>†</sup> Including cases under investigation.

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

**Figure 7. Adult AIDS cases by year of diagnosis**

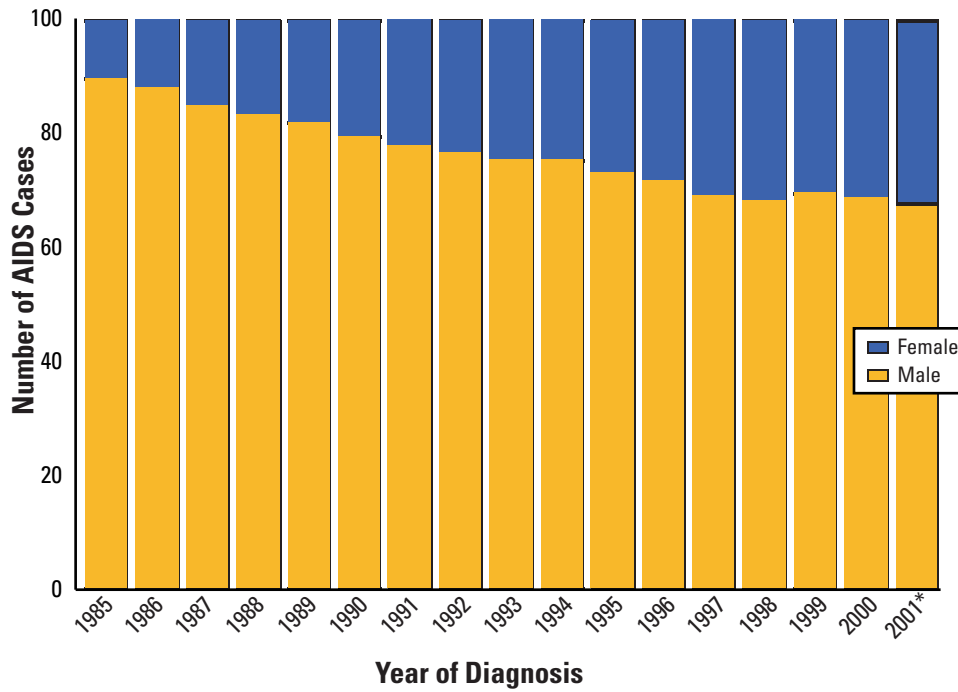


**Figure 8. Pediatric AIDS cases by year of diagnosis**

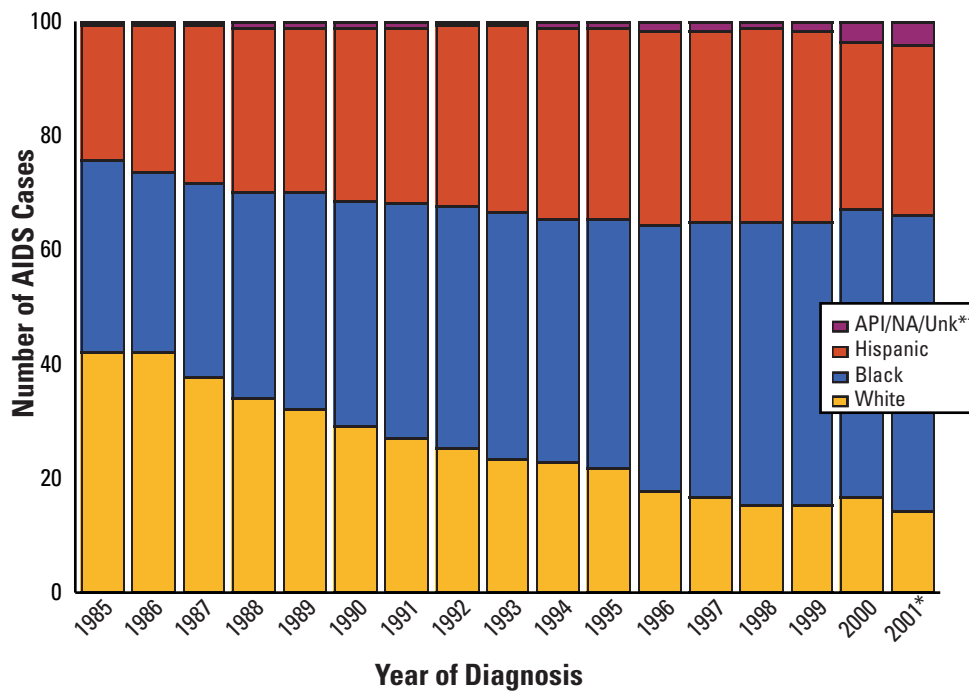


\* Data are incomplete due to reporting lag.

**Figure 9. Adult AIDS Cases by gender and year of diagnosis**



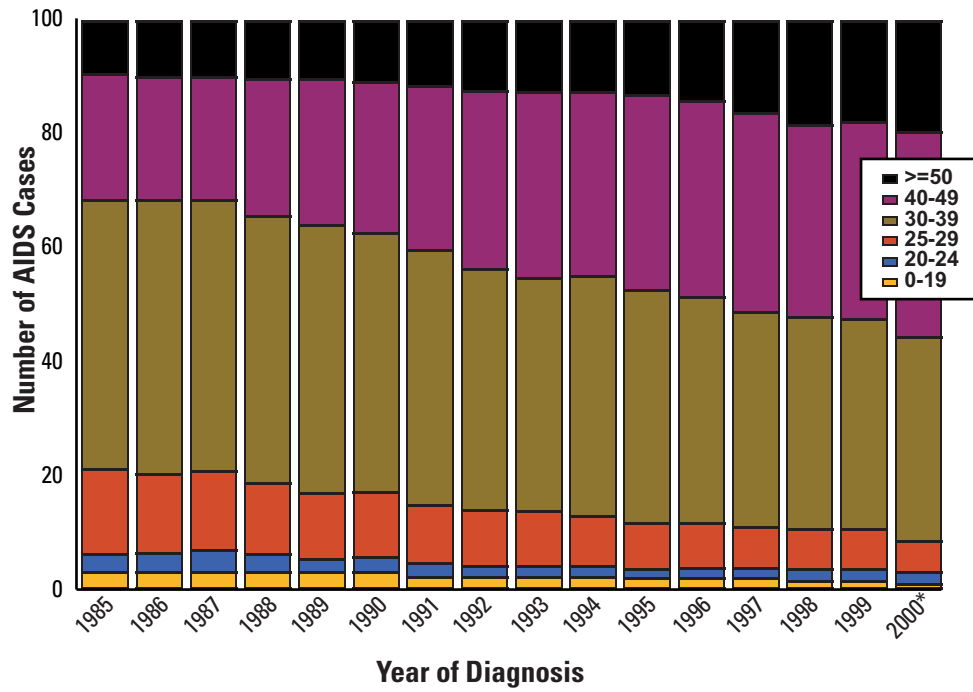
**Figure 10. Adult AIDS cases by race/ethnicity and year of diagnosis**



\* Data are incomplete due to reporting lag.

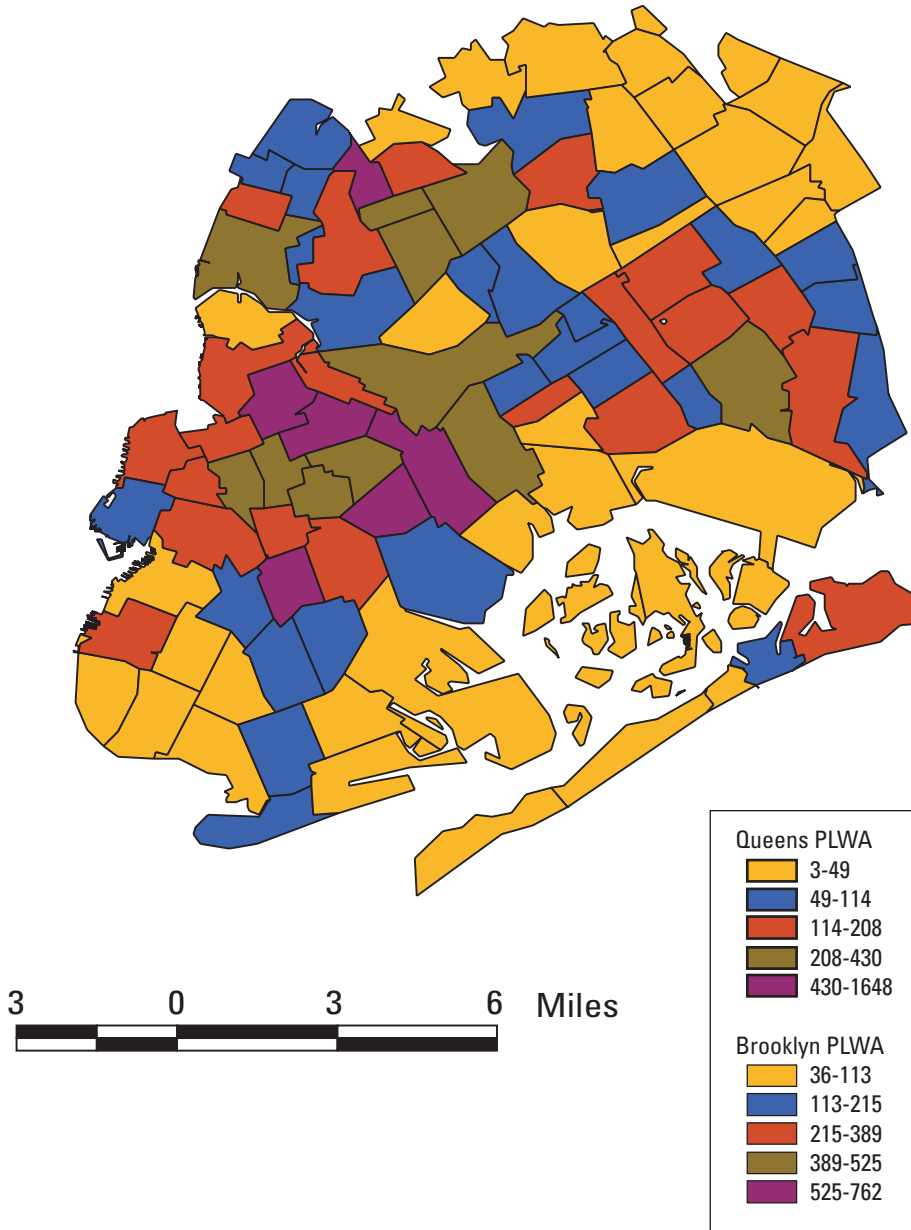
\*\* API=Asian Pacific Islander; NA=Native American; Unk=Unknown.

**Figure 11. Adult AIDS cases by age group and year of diagnosis**

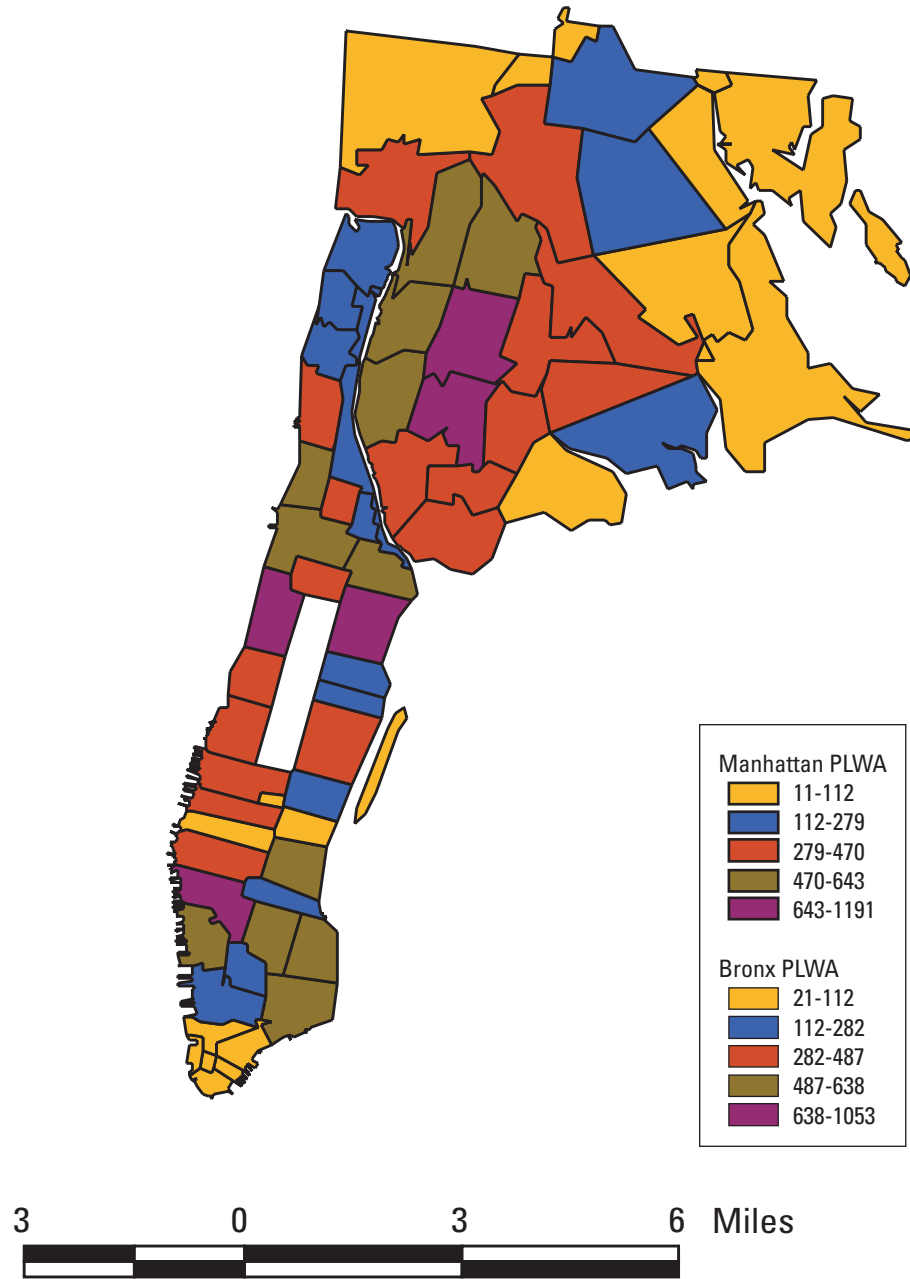


\* Data are incomplete due to reporting lag.

**Figure 12. People living with AIDS 2000: Queens and Brooklyn**



**Figure 13. People living with AIDS 2000: Manhattan and the Bronx**



**Figure 14. People living with AIDS 2000: Staten Island**

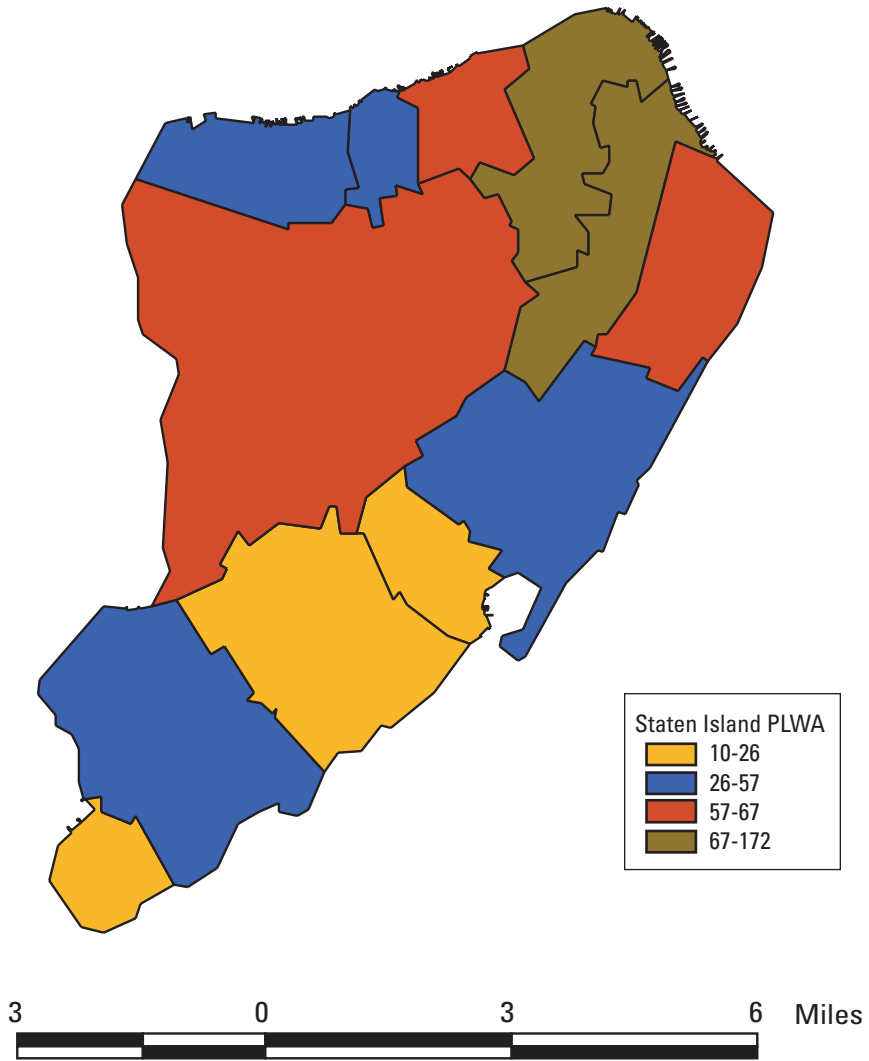


Table 2 presents the race and borough distribution of AIDS prevalence in New York City and the percentage of new Title I clients by service-related Work Group areas in 2000 (also known as Year 10).

<b>Planning Council Work Groups for New York City</b>	
Alcohol and Other Drugs (AOD) Services	Infrastructure
Health Services	Mental Health Services
Housing Services	Social Services

This table demonstrates that the epidemic disproportionately impacts 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 3 and 4 present co-morbidity data, including poverty and lack of insurance. Table 3 presents information on co-morbidities for the EMA, or in some cases the New York City population. Table 4 focuses on co-morbidities among CHAIN participants. The CHAIN data shows a decline over time in all co-morbidities.

## Services and Resources

This section provides an inventory of the HIV/AIDS-related primary care and support services that are available in New York City. It includes organizational capability and capacity and service barriers.

Table 5 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 that 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.

**Table 2. 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	I	
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.

\*ADAP: AIDS drug assistance program.

**Table 3. Co-Morbidity, Poverty, and Insurance Status for the New York EMA**

<b>Co-morbidity</b>	<b>Prevalence Within the General Population Within New York City</b>
<b>A</b>	<b>B</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 = 1.6:100,000 (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 4. Co-Morbidity, Poverty, and Insurance Status Among CHAIN Participants, Over Time for New York City**

Co-morbidity	Percent 9/94-9/95 n*=700	Percent 2/96-12/96 n=480	Percent 11/98-1/00 n=508
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

\*n=sample size.

**Table 5. Core HIV/AIDS Service Categories and New Clients<sup>3</sup> 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
<b>HEALTH CARE SERVICES PROGRAM CATEGORIES</b>											
Reimbursement pools <sup>4</sup>	\$16,671,000	1			23.7%	28.4%	29.8%	16.4%		1.7%	
Air Bridge Project <sup>5</sup>	\$701,155	3			32.8%	7.0%	24.0%	18.8%			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			23.3%	26.9%	37.1%	5.4%			7.3%
Treatment education <sup>6</sup>	\$1,343,423	10			27.0%	3.4%	45.6%	18.6%			5.5%
Tuberculosis services	\$1,648,294	6			11.3%	16.3%	54.6%	2.1%			15.6%
Dental care	\$475,334	3			19.8%	43.7%	29.1%	4.3%		0.3%	2.8%
Adult day treatment	\$803,788	3			43.8%	2.0%	17.6%	30.7%			5.9%
Primary care development in community health centers and substance abuse centers <sup>7</sup>	\$2,960,778	6									
Service enhancements to substance abuse treatment programs, women and children's integrated HIV services, and treatment adherence demonstration projects <sup>7</sup>	\$4,595,258	20									
Treatment adherence support	\$90,013	2									
Assessment teams in ER/harm reduction settings	\$33,825	1									
Hepatitis C screening and treatment	\$125,194	2									
Outstationed medical care teams in SROs	\$98,852	1									

<sup>3</sup> 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.

<sup>4</sup> 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.

<sup>5</sup> 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.

<sup>6</sup> Includes programs that did not provide direct services to clients.

<sup>7</sup> These programs are administered by the New York State AIDS Institute through a single contract with MHRA.

**Table 5. Core HIV/AIDS Service Categories and New Clients<sup>3</sup> 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
<b>HOUSING PROGRAM CATEGORIES</b>											
Housing placement assistance	\$554,250	2		39.4%	22.3%	22.9%	6.3%				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		<b>Data not available</b>							
<b>MENTAL HEALTH PROGRAM CATEGORIES</b>											
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		<b>Data not available</b>							
<b>HARM REDUCTION PROGRAM CATEGORIES</b>											
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%
<b>SOCIAL SERVICE PROGRAM CATEGORIES</b>											
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%				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 5. Core HIV/AIDS Service Categories and New Clients<sup>a</sup> 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	
<b>INFRASTRUCTURE PROGRAM CATEGORIES</b>												
Building and sustaining organizational capacity	\$2,489,522	13										
Enhancing staff capacity to serve people living with HIV/AIDS	\$260,828	2										
<b>MINORITY HIV/AIDS INITIATIVE<sup>a</sup> PROGRAM CATEGORIES</b>												
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.

<sup>a</sup> These programs were originally referred to as "CBC," or "Congressional Black Caucus" programs.

In a recent collaboration between Columbia University and MHRA, the CHAIN cohort's service utilization was geographically displayed for presentation to the Planning Council. 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. (Title I data are from Year 10, which is fiscal year 2000.) 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.

Appendix C presents six New York City maps generated from this database. The maps display the distribution and location of six 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:

- A higher concentration of health services exist in lower and northern Manhattan and the 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 provide supportive mental health services.

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

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

Table 6 show approximate levels of Federal, State, and local funding for the major service categories compared to Title I funding. The other funding sources may include Medicaid, Title II, Title III, Title IV, HOPWA, other HUD, the CDC and substance abuse funding. The amounts are for the entire New York EMA.

## Organizational Capability and Capacity

This section describes provider technical assistance (TA) needs, barriers to receipt of services, and organizational strategies for overcoming barriers.

**Table 6. 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 Funds
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	0.0	\$122.5
Other outpatient/community-based health care services	\$27.3	\$152.2	\$116.6	\$30.3	\$326.4
Inpatient medical care services	0.0	\$327.1	\$163.6	\$163.6	\$654.2
Grantee administrative costs, planning council support, program support, and other activities	\$17.3	0.0	0.0	0.0	\$17.3
<b>Total funds</b>	<b>\$119.3</b>	<b>\$1,067.2</b>	<b>\$643.9</b>	<b>\$509.2</b>	<b>\$2,339.6</b>

Source: New York City Department of Health, 2002.

*Definitions of service categories:*

Home/community-based support services includes funds available to serve persons/families with HIV/AIDS, by funding source, to provide: buddy/companion programs, case management, client advocacy, psychosocial support services, day/respite care for children or adults, outreach services, health education/risk reduction, food services (home delivered meals, food banks, nutritional supplements), housing assistance/housing-related services, transportation, emergency financial assistance, and other support services.

Ambulatory/outpatient medical care includes ambulatory/outpatient medical care and medications. AIDS Drug Assistance Program includes funds available to support the State ADAP. Column B includes the amount of funds the Planning Council allocated from the EMA's Title I funding to support the State ADAP. Columns C and D include only the amount of funding supporting people with HIV/AIDS within the geographic area of the EMA, not the entire State.

Other outpatient/community-based primary medical care services includes funds available to serve persons/families with HIV/AIDS to provide oral health, home primary medical care, mental health services, rehabilitation services, substance abuse services, other outpatient/community-based health care services not included in the service categories listed above.

Inpatient medical care services includes funds available to serve persons/families with HIV/AIDS to provide inpatient personnel costs that prevent unnecessary hospitalizations and/or that expedite discharge as medically appropriate, as specified under Title I of the CARE Act and other inpatient medical care services not funded with CARE Act funds.

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In 2001, an initiative sponsored by the Planning Council began to collect data on technical assistance service needs in the New York EMA.<sup>9</sup> 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 effect 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.
- **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 effect 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 the organizational ability that was already in place.
- **Future TA Needs.** As shown in Figure 10 in the *Initial Needs Assessment* (page 94), 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.

## New York City Service Barriers and Strategies to Address Them

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, efforts to eliminate barriers succeeded in decreasing the number 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.

A list of barriers, by special populations, as well as potential strategies to overcoming them can be found in Table 12 of the *Initial Needs Assessment* (pages 97-107). While some barriers are unique to a given population, many affect multiple populations. Barriers 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 (alcohol and other drug users), MICAs (mentally ill, chemical abusers), immigrants/ undocumented, recent detainees/ releasees, and the unconnected—each encounter problems associated with gaining access to and

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<sup>9</sup> 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 available in September 2002. The study gathered data from 71 HIV/AIDS agencies within the New York EMA.

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 would 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 in the *Initial Needs Assessment* (pages 108-113) reports cost and outcome effectiveness data. 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.

## New York City Service Gaps

An important step in service planning is analyzing the relationship among the services being provided, the services being sought by clients, and the services actually needed by the HIV/AIDS population as a whole.

The *Initial Needs Assessment* 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. See *Initial Needs Assessment* Table 15 (pages 136-138) and Table 16 (pages 139-142).

Appendix D 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. In total, the data suggests the following:

- Health care services are generally available to people with HIV/AIDS living in New York City, even the most disenfranchised groups. This is accomplished primarily through Medicaid and ADAP Plus.
- Numerous qualitative and quantitative sources 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 the general population. As discussed more extensively in Section 6 of the *Initial 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. 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, although a CHAIN overview report found that the CHAIN participants who had AOD problems stated that treatment is important to them, only half of these individuals received treatment in the last six months. However, 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 with mental illness. 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 about half of the respondents did not receive dental care in the prior 18 months, in many instances access barriers (not knowing where to find a dentist; fear of dental work) prevented individuals from connecting to care, not a lack of available dental care. As with mental health and AOD services, further quantitative research on the extent to which

dental care is available may be needed before reaching a final conclusion that a service gap exists in this area.

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.

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.<sup>10</sup> Therefore, HIV health and social services planning must consider the needs of persons aware of their status who are not in care.

Table 16 of the *Initial Needs Assessment* (pages 139-142) examines issues related to the broader category of those 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.

## B. Tri-County Region Needs Assessment

The New York EMA is composed of five boroughs of New York City and three counties directly north and northwest of the City (Westchester, Rockland, and Putnam). The New York EMA Planning Council relies on the Tri-County Title I Steering Committee to provide leadership on planning and recommendations to the Planning Council on

<sup>10</sup> 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 chronically 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 x 3.5%, or 2,520; (3) the middle number estimated to be unconnected would be 72,000 x 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.

priorities and resource allocations for the Tri-County region. The Title I Steering Committee is convened by the Westchester County Department of Health (WCDOH), which is also responsible for the administration of Title I programs in the region. The Title I Steering Committee conducts much of the detailed planning work through four subcommittees (Health, Housing, Case Management, Mental Health/Substance Use), a work group (Support Services), and the PWA Advisory Group (Living Together).

As of June 30, 2000, a total of 5,055 cumulative adult and adolescent AIDS cases had been diagnosed in the Tri-County region<sup>11</sup>—of these, 2,430 people were known to be living with the disease.<sup>12</sup>

The largest proportion of cumulative AIDS cases, 50% (n\*=2,517), result from injecting drug use (IDU) with an additional 4% (n=179) of men having sex with men (MSM)/IDU cases. Of those living with AIDS, 49% (n=1,190) have a history of IDU with an additional 3% (n=75) MSM/IDU cases.

In the Tri-County region, the disease disproportionately affects men and people of color. Specifically,

- Males make up 72% of cumulative cases and 67% of living cases;
- People of color represent 67% of cumulative cases and 74% of living cases.

Disease demographics, captured in AIDS cases reported during the period July 1998 through June 2000 (n=430) for the Tri-County region, indicate the following trends:

- **Gender:** The Tri-County region continues to see an HIV epidemic increasingly affecting women, consistent with a statewide trend. However, the percentage of cumulative AIDS cases among women (28%) is significantly higher than statewide (23%) and national (17%) cases.<sup>13</sup> From July 1998 through June 2000, women accounted for over one-third or 35% (n=149) of all new AIDS cases.
- **Race:** As is the case across many other counties in New York State, the Tri-County epidemic continues to disproportionately affect communities of color. People of color accounted for over two-thirds or 79% (n=339) of all new AIDS cases reported from July 1998 through June 2000. In the Tri-County region, Blacks, who represent less than 13% of the Tri-County population, account for 49% of cumulative AIDS cases—significantly higher compared to statewide

<sup>11</sup> “Cumulative Number of Adult (13 Years and Older) AIDS Cases Including NYS Prison Inmates, by Age, Race, Sex and Risk,” Table 4H, AIDS Surveillance Quarter Update, Data as of June 30, 2000, NYS DOH/BHAE.

<sup>12</sup> “Presumed Alive Adult (13 Years and Older) AIDS Cases Including NYS Prison Inmates by Age, Race, Sex and Risk,” Table 6H, AIDS Surveillance Quarter Update, Data as of June 30, 2000, NYS DOH/BHAE.

<sup>13</sup> NYS Department of Health, Bureau of HIV/AIDS Epidemiology (Tri-County and NYS AIDS data), June 30, 2000 and Centers for Disease Control (CDC), June 30, 2000 (National AIDS data).

\*n=sample size.

(42%) and national (37%) cases.<sup>14</sup> From July 1998 through June 2000, Blacks accounted for almost two-thirds or 60% (n=256) of all new AIDS cases. Hispanics, who represent less than 14% of the population, account for 18% of cumulative AIDS cases—significantly lower than statewide (30%) cases.<sup>15</sup> From July 1998 through June 2000, Hispanics of all races accounted for 19% (n=83) of all new AIDS cases. Asians, Pacific Islanders and Native Americans, who comprise some 6% of the population, account for less than 1% (n=14) of cumulative AIDS cases.

- **Risk:** In the Tri-County population, injection drug use (IDU) clearly continues to drive the epidemic, accounting for 50% of cumulative AIDS cases – significantly higher compared to statewide (44%) and national (25%) cases.<sup>16</sup> From July 1998 through June 2000 injecting drug use accounted for almost half or 49% (including 3% among MSM/IDU) of all new AIDS cases. Likewise, heterosexual exposure to HIV accounted for an increasing proportion of AIDS cases as well. While 14% of cumulative AIDS cases – significantly higher than statewide (9%) and national (11%) cases<sup>17</sup>—was attributed to heterosexual contact, over a quarter (29%) of newly reported AIDS cases resulted from heterosexual exposure to HIV from July 1998 through June 2000.
- **Age:** By age, the epidemic has had its most devastating effects on people in their thirties. While only 15% of the Tri-County population is comprised of people between the ages of 30-39,<sup>18</sup> they represent 42% of all cumulative cases.<sup>19</sup>

It is also valuable to examine general demographic data as a backdrop to the epidemiological profile. In some cases it further demonstrates populations disproportionately affected by HIV/AIDS.

Between 1990 and 2000, the total population of the Tri-County region grew by 6% (from 1,224,282 to 1,305,957). The Hispanic population—regardless of race—grew by 38% (from 106,151 to 172,937), the Asian/Pacific Islander population grew by 16% (from 43,680 to 52,423), the Black population grew by 9% (from 147,514 to 162,357), and the White population fell by 3% (from 998,993 to 965,496).

Table 7 presents co-morbidity data, including poverty and insurance status for the Tri-County region.

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<sup>14</sup> NYS DOH/BHAE, June 30, 2000 (Tri-County and NYS AIDS data) and CDC, June 30, 2000 (National AIDS data)

<sup>15</sup> Ibid.

<sup>16</sup> Ibid.

<sup>17</sup> Ibid.

<sup>18</sup> DP-1. Profile of General Demographic Characteristics: 2000. Data Set: Census 2000 Summary File (SF 1) (Putnam, Rockland, Westchester Counties), 2000 Census, U.S. Census Bureau.

<sup>19</sup> “Cumulative Number of Adult (13 Years and Older) AIDS Cases Including NYS Prison Inmates, by Age, Race, Sex and Risk,” Table 4H, AIDS Surveillance Quarter Update, Data as of June 30, 2000, NYS DOH/BHAE.

**Table 7. Co-Morbidity, Poverty, and Insurance Status for the Tri-County Region**

<b>Co-morbidity</b>	<b>Incidence Within the General Population Within the Tri-County Region</b>
<b>A</b>	<b>B</b>
Tuberculosis	In Westchester, 65 cases of TB, 7 cases of TB/HIV co-infection; in Rockland, 29 cases of TB and 5 cases of TB/HIV co-infection; in Putnam, 1 case of TB. <sup>20</sup> (T149)
Syphilis (primary and secondary)	In Westchester, 2 cases of primary syphilis and 48 cases of non-congenital syphilis; in Rockland, 1 case of primary syphilis and 17 cases on non-congenital syphilis, 16 cases of early latent syphilis; in Putnam, 1 case of latent syphilis <sup>21</sup> (T150)
Gonorrhea	In Westchester, 296 cases; in Rockland, 56 cases; in Putnam, 4 cases. <sup>22</sup> (T150)
Chlamydia	In Westchester, 1,155 cases (982 female, 173 male); in Rockland, 119 cases (106 female, 13 male); in Putnam, no data available. <sup>23</sup> (T151)
Intravenous Drug Use	11,466 persons <sup>24</sup> (T152)
Other Substance Abuse (i.e. alcohol, methamphetamine, cocaine, inhalants)	103,202 persons <sup>25</sup> (T152)
Homelessness	In Westchester, 2,972 persons, including 214 homeless living with HIV in a system of care; in Rockland, 547 persons; in Putnam, 25 persons. Data not available for homeless living with HIV in Rockland and Putnam. <sup>26</sup> (T153)
Insurance Status	Estimated percentage and number in the Tri-County region without insurance coverage, including without Medicaid, 222,620 (17.5%) of the general population. <sup>27</sup> (T154)
Poverty	114,560 persons (8.7% of the population) at 100% poverty level. <sup>28</sup> (T155)

## Services and Resources in the Tri-County Region

In order to better assess the needs of people living with HIV/AIDS in the Tri-County region, in 2001 the Title I Steering Committee voted to analyze HIV/AIDS service provision according to zip-code-defined health planning regions (HPRs) matching a model used to track STDs (see Table 8). Six zip-code-defined HPRs encompass Westchester County: Southwest (the City of Yonkers); Southeast (which includes the cities of Mount Vernon and New Rochelle); East (which includes the village of Port Chester); Northeast (which includes the village of Mount Kisco); Northwest (which includes the town of Peekskill); and West Central (which includes the county seat, the City of White Plains); Rockland County, west of the Hudson River and Putnam County, directly north of Westchester County, constitute the remaining two HPRs.

In March 2002, a survey was mailed to 32 HIV/AIDS service providers in the Tri-County region in order to collect data and information about the current service delivery system and to determine gaps in care for geographic communities and special populations. Included with the survey was a list of 20 distinct HRSA service categories adopted by the Title I Steering Committee as the continuum of care. Each agency was asked to fill out a survey for each of the service categories, which it provided in the region regardless of funding source. Twenty-nine providers (91%) responded, mailing in 60 separate surveys. Preliminary findings indicated:

- Respondents reported that the Southwestern Westchester HPR (Yonkers) receives the most services in the continuum of care: 16 out of 20 possible

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<sup>20</sup> "Confirmed Cases of Tuberculosis and STDs, 2000," NYS DOH, Bureau of Infectious Disease, October 2001.

<sup>21</sup> "Confirmed Cases of Tuberculosis and STDs, 2000," Westchester County DOH, Division of Disease Control, NYS DOH HIN (data for Westchester and Putnam Counties). Data for Rockland County provided by the Department of Health.

<sup>22</sup> Ibid.

<sup>23</sup> "Confirmed Cases of Tuberculosis and STDs, 2000," WCDOH, Division of Disease Control, NYS DOH HIN. Data from Rockland County provided by Rockland County Department of Health (as of December 31, 2000).

<sup>24</sup> "Selected Characteristics of Clients Admitted to ASA Treatment (1999), Primary Drug of Abuse (All Service Categories), Table 10," Year 2000 County Resource Book for Alcohol and Substance Abuse Services Planning, NYS OASAS.

<sup>25</sup> Ibid.

<sup>26</sup> "Homeless Data," Westchester County Department of Social Services, August 2001. "Homeless Data," Rockland County Department of Health, October 2001. "Homeless Data," Putnam County Department of Social Services, October 2001.

<sup>27</sup> "Health Insurance Coverage, Current Population Survey, March 1996," U.S. Census Bureau. Most current data available at the county level.

<sup>28</sup> "County Estimates for People of All Ages in Poverty in New York: 1997," U.S. Census Bureau. Most current data available at the county level.

**Table 8. Tri-County Providers Serving Health Planning Regions (HPRs)\***

# of Agencies Providing Services <sup>+</sup>	Service Category	Putnam County	Rockland County	Westchester County						
				Southeastern	Southwestern	West Central	East Central	Northwestern	Northeastern	J
A	B	C	D	E	F	G	H	I	J	
	% of HIV/AIDS Cases	3%	14%	25%	27%	11%	5%	12%	3%	
<b>Health Services</b>										
8	Ambulatory/Outpatient Medical	2	4	3	3	2	3	4	2	
3	Counseling & Testing	1	1	1	2	1	2	2	1	
2	Dental Care	1	1	1	1	2	2	2	2	
1	Treatment Adherence Services			1						
3	Case Management Medical Based		1	1	1					
<b>Case Management and Supportive Services</b>										
6	Case Management Non-Medical	4	3	4	5	3	3	3	3	
6	Food Bank/Home Delivered Meals	1	1	2	1	1		2		
1	Respite Care/Buddy Services	1	1	1	1	1	1	1	1	
2	Legal Services	1	1	1	1	1	1	1	1	

\* Numbers indicate providers reporting the service is available to clients located in HPR.

<sup>+</sup>Although services may be currently provided, no responses were received from providers indicating that home health care, hospice services, rehabilitation services, and housing assistance were being accessed in any of the HPRs.

**Table 8. Tri-County Providers Serving Health Planning Regions (HPRs)\*, continued**

# of Agencies Providing Services <sup>+</sup>	Service Category	Putnam County	Rockland County	Westchester County						
				Southeastern	Southwestern	West Central	East Central	Northwestern	Northeastern	
A	B	C	D	E	F	G	H	I	J	
<b>Case Management and Supportive Services, continued</b>										
7	Outreach		1	3	3	2	3	2	1	
2	Permanency Planning	1	2	1	1	1	1	1	1	
5	Psychosocial Support Services	1	1		2					
1	Transportation	1	1	1	1	1	1	1	1	
<b>Mental Health and Substance Use Services</b>										
3	Mental Health Services	1	1		1			1	1	
1	Substance Use Services	1	1	1	1	1	1	1	1	
<b>Housing Services</b>										
6	Housing Assistance	2	2	2	2	1	1	1	1	

\* Numbers indicate providers reporting the service is available to clients located in HPR.

<sup>+</sup>Although services may be currently provided, no responses were received from providers indicating that home health care, hospice services, rehabilitation services, and housing assistance were being accessed in any of the HPRs.

service categories, with Rockland County HPR receiving 15 services, and Putnam County HPR receiving 14 services.

- Northeast, West Central, and East Central Westchester HPRs accounted for regions with the least number of services reported as provided. Providers in East Central Westchester reported only 11 services, while providers in Northeast and West Central Westchester both reported only 12 out of a possible 20 service categories.
- Of the surveys received, the two service categories most cited as being provided in the HPRs included *Ambulatory/Outpatient Medical Care* and *Non-Medical Case Management*. These service categories were reported to be provided in all eight health planning regions.
- The three service categories reported to be least provided in various HPRs were *Treatment Adherence*, *Medically-Based Case Management*, and *Psychosocial Support*. Treatment Adherence was reported as not being provided in seven of the eight HPRs, and both Medically-Based Case Management and Psychosocial Support were reported as not being provided in five of the eight HPRs, respectively.
- None of the providers reported receiving funding for the four following HRSA service categories in the Tri-County region: *Hospice Services*, *Housing-Related Services (referral/search/placement)*, *Nutritional Counseling*, and *Rehabilitation Services*. However, some of these services may be currently provided as components in the continuum of care in the region. For example, some case managers may perform housing-related services for the homeless population and nutritional counseling may be provided as part of ambulatory/outpatient medical care on an as-needed basis.

### Tri-County Region Service Barriers and Strategies to Address Them

Findings from the Tri-County HIV/AIDS Provider Survey suggest that several barriers to care exist for people living with HIV disease in the Tri-County region.

- Providers report that a lack of transportation presents a barrier to consumers when accessing services. The Tri-County region consists of urban, suburban, and rural areas. The services utilized by people living with HIV disease are often at some distance from where they live.
- Twenty-two percent (22%) of the respondents to the provider survey thought that a lack of referral of clients across agencies presented a barrier for the client in accessing the fullest range of services for the individual. Respondents indicated that there was a need for more networking and exchange of information across agencies.
- Although services may be available to people living with HIV/AIDS, services cannot be administered if those in need are not identified. Thirteen percent (13%) of the service providers who responded listed difficulties with the client engagement process. They also cited that identification of those in need of service (HIV infected consumers) was a barrier.

- A lack of information about available services is a barrier to care. Often services within an agency become difficult to access due to poor communication among the staff and clients. In addition, accessing services is also difficult if the potential clients do not know how to access services or are afraid of getting involved in an organization. Ten percent (10%) of the service providers indicated that although they were offering services to the community, there were still barriers due to fear and a lack of awareness of available services.
- Cultural diversity in the Tri-County region has increased over the past 10 years. The populations that are affected by HIV/AIDS have also diversified. Thirteen percent (13%) of the responses indicated that the limited availability of culturally sensitive and bilingual service providers presented a barrier to service. In order for people to be served, they need to feel their cultural values are understood, and that they can communicate in a language with which they feel comfortable.
- People living with HIV/AIDS need affordable, safe, and available housing. Ten percent (10%) of the providers indicated that the lack of housing for people living with HIV/AIDS presented a barrier to other services.

### Tri-County Region Service Gaps

Service needs as identified by respondents to the Tri-County HIV/AIDS Provider Survey 2001/2002 are as follows:

- **Ambulatory/Outpatient Medical Care.** *Culturally competent providers; bilingual mental health service providers and outreach to Haitian, Central American, and other immigrants for testing/treatment.* The most frequently cited gap in service by Tri-County service providers has to do with how services are delivered to people of different cultural backgrounds. Thirty-two percent (32%) of the respondents stated that there is a need in the Tri-County region for service providers to become culturally competent. Agencies expressed a need for bilingual staff members and culturally sensitive programs. In addition, outreach workers need to be able to connect with groups such as Haitian, Central American and other immigrants for counseling, testing and treatment.
- **Housing and rent subsidies.** People living with HIV/AIDS find it difficult to adhere to the rigors of a medical treatment program if they do not have stable living conditions. Therefore it is not surprising to find that 25% of the provider respondents indicate a need for increased housing opportunities as well as rent subsidies for the Tri-County region. Finding affordable, safe and available housing for people living with HIV/AIDS is difficult and costly. Additional funding for housing and rent subsidies would be helpful.
- **Transportation (reliable).** The Tri-County region covers approximately 600 square miles. Rockland County to the west is separated from Westchester and Putnam Counties by the Hudson River, while both Westchester and Putnam Counties have urban, suburban and rural communities divided by major interstate highways. HIV/AIDS services utilized by people living with HIV/AIDS are often

some distance from where they live. Transportation is an important element of the service delivery system. Twenty-two (22%) of the service providers indicated gaps in the transportation system in the Tri-County region. Public transportation is limited and links both within and between counties are often a barrier to care.

- **Program Development.** *Funds to expand current programs.* More than one-fifth (22%) of the respondents indicate that many consumer needs are addressed by existing programs, however, these services could be expanded and more people could be served with increased funding.
- **Mental Health/Substance Use Services.** *MICA day treatment services, shortage of psychiatrists.* A gap in day treatment programs for the HIV-positive MICA population was indicated by 17% of the service providers. In addition, there is a shortage of psychiatrists providing mental health services.
- **HIV Prevention Education, Testing and Treatment.** *Testing, treatment, and education for adolescents.* Fifteen percent (15%) of survey respondents indicated that there were gaps in testing, treatment, and education for adolescents.
- **Support Services.** *Childcare for mothers to keep appointments.* Twelve percent (12%) of survey respondents indicated that there were gaps in available childcare for mothers seeking services.



## Goals and Objectives for 2002-2005: Where Are We Going?

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### A. How the Plan Was Developed

This chapter presents the goals and objectives for the New York EMA for 2002 to 2005. The planning process began with the adoption of principles of planning and a vision statement.

#### Principles of Planning

The following principles describe the broad, basic rules governing the planning process:

- Be rooted in a clear understanding of the changing environment.
- Be evidence-based, relying primarily on quantitative data but also informed by qualitative data.
- Be realistic in scope and content.
- Be expressed in simple, streamlined language.
- Inform the yearly prioritization and allocation process.
- Be revisited over time and adjusted as needed.
- Focus ultimately on the achievement of desired outcomes (changes in consumers' lives, rather than on actions taken or processes completed).
- Be in keeping with the U.S. Health Resources and Services Administration (HRSA) mandates and guidelines.
- Reflect coordination across Work Groups and with other funding streams.

## Values

The following values describe the underlying concerns of the Planning Council. These values sum up what is meant by “appropriate” and “quality” care.

- Be consumer focused. For example, ensure cultural relevancy and remove service barriers.
- Focus on avoiding gaps in the continuum of care and encouraging coordination across the continuum<sup>29</sup>.
- Define the continuum of care broadly (for example, to include housing and other basic living needs in addition to medical needs).
- Focus on meeting the needs of all consumers with an emphasis on:
  - affected sub-populations and historically underserved communities,<sup>30</sup>
  - those with severe needs (for example, the dually diagnosed), and
  - those who are not in care (both diagnosed and undiagnosed).

## Vision of the Planning Council

The vision statement describes the overarching and long-range goals of the Planning Council.

It is the vision of the HIV Health and Human Services Planning Council of New York that people living with HIV disease in the New York EMA will have access to appropriate, quality services across the continuum of care, resulting in the best possible health and quality of life.

<sup>29</sup> HRSA is particularly concerned with the coordination HIV prevention programs (including outreach and early intervention programs) and programs focused on prevention and treatment of substance use.

<sup>30</sup> Targeted sub-populations include:

- Infants and children (under 13 years old)
- Youth 13-24
- Injection drug users (IDUs)
- Substance users other than IDUs
- Men of color who have sex with men
- White men who have sex with men
- Women of child-bearing age (13 or older)
- Detained inmates and recently released inmates
- Mentally ill chemical abusers (MICAs)
- Recent immigrants and/or undocumented persons
- Homeless persons (in shelters, SROs, and “on the street”)

## Setting Goals and Objectives

Following the development of the needs assessment, the second phase of the strategic planning process involved a series of structured working sessions with each of the six Planning Council Work Groups, the Tri-County Steering Committee, and the Data and Policy Committees.

During Spring 2002, approximately three dozen sessions were held, including four meetings with each of the six Planning Council Work Groups; multiple meetings with the PWA Advisory Group, Tri-County region staff and Steering Committee members, the Data Committee, and the Policy Committee. Note that an ongoing linkage with the PWA Advisory Group was maintained to facilitate its members' participation in the Work Group activities to develop goals and objectives.

Meeting agendas are outlined below for the four sessions to develop goals and objectives. Prior to each of the second through fourth sessions, participants were assigned homework. For example, during the first meeting members were asked to review the portion of the 1998 *Strategic Plan* that most directly applied to their Work Group or committee and determine which goals, objectives, and action steps (if any) should be included in the new plan. The homework assigned in each previous session served as the starting point for the next session's activities. This allowed all members of the Work Group or committee to give their input at each stage of the process without depleting limited time during the sessions.

### Meeting 1:

- Review of planning timeline; establishment of a meeting schedule for the next three meetings.
- Review of planning principles.
- Overview of the *Initial Needs Assessment* document and its role in plan development.
- Review of the planning template.
- Discussion of goals and their characteristics.
- Explanation of homework for Meeting 2: review of the 1998 *Strategic Plan* and determination of which goals, objectives, and action steps should be included in the current plan; determination of needed data that was not included in the Initial Needs Assessment.

## Meeting 2:

- Review of homework results.
- Reach agreement on goals (with the understanding that changes could be made at a later date).
- Discussion of objectives and their characteristics.
- Explanation of homework for Meeting 3: suggest objectives for each goal selected by the Work Group.

## Meeting 3:

- Review of homework results.
- Reach agreement on objectives (with the understanding that changes could be made at a later date).
- Discussion of action steps and their characteristics.
- Explanation of homework for Meeting 4: suggest action steps for each objective selected by the Work Group.

## Meeting 4:

- Review of homework results.
- Reach agreement on action steps (with the understanding that changes could be made at a later date).
- Discussion of measures and their characteristics.
- Suggestions for potential measures.

Since fewer sessions were held with the Data and Policy Committees, meeting agendas were consolidated for those groups. In addition, the Immigrant and Prison Planning Committees submitted recommendations to the Social Services and AOD Work Groups respectively. The Tri-County Steering Committee conducted two half-day planning summits.

The Planning and Evaluation Committee and the Planning Council adopted the goals and objectives for New York City and the Tri-County region during their respective June 2002 meetings.

## B. Goals and Objectives for the Service System

This section presents the goals and objectives for 2002-2005. Also included are action steps and time frames for action. Chapter 3 presents the framework for monitoring and evaluating these objectives.

Points to keep in mind:

- Goals are broad and overarching – and embrace a 3-year period.
- Objectives are proxy measures for goal attainment.
- Together, goals and objectives provide a road map for the Planning Council to annually set priorities and determine resource allocations for Title I.

Measurement is necessary to consider when implementing action steps. Readers are urged to refer frequently to Chapter 3 of this plan for details on the measures for each of objectives presented on the following pages.

### Who is responsible for implementing the plan?

The Planning Council will use this plan to assist them in fulfilling their HIV services planning duties between 2002 and 2005.

During the annual planning cycle, the Planning Council will continue to gather and analyze a range of information, special studies, and other data. The plan, and its accompanying needs assessment, can be used to guide the questions that are asked of these new data, and to focus attention on what those topics say about the goals and objectives described in the plan.

Once a year, immediately prior to the start of the annual priority setting and resource allocation process, the Planning Council, beginning with its Work Groups, will be presented with a measurement report. This report will provide each Work Group, and the Planning Council, with current data on the measures presented in Chapter 3. Based on the results of the measurement report, Work Groups may decide to adjust the goals and objectives presented here.

Following this step, the Work Groups can then proceed to set priorities and determine resource allocations for the upcoming fiscal year.

Implementation of action steps within a Work Group's goals and objectives primarily are the responsibility of that particular Work Group (and in the case of the Tri-County region, its Steering Committee). Additional steps may be appropriate as objectives are pursued.

Beyond the efforts of the Work Groups, the Tri-County Steering Committee, and other committees, implementation of the plan's goals and objectives typically will require the involvement of a core group of responsible parties:

- Planning and Evaluation Committee
- Executive Committee
- Planning Council
- New York City Department of Health (NYCDOH) (for those functions that are the responsibility of the grantee) and the Westchester County Department of Health (for those functions that are the responsibility of the Tri-County region sub-grantee)
- Medical and Health Research Association of New York (MHRA), (for those functions that are the responsibility of the master contractor)

Where appropriate, parties other than this core group are indicated.

## How to use this section

A total of nine sets of goals and objectives appear below.

First are the six New York City Work Groups, alphabetically:

- Alcohol and Other Drug (AOD) Service Work Group, pages 58-60
- Health Services Work Group, pages 61-64
- Housing Work Group, pages 65-67
- Infrastructure Work Group, pages 67-69
- Mental Health Work Group, pages 69-71
- Social Services Work Group, pages 72-75

Pages 76-81 discuss the Tri-County region. Data and policy goals and objectives of the Planning Council appear on pages 82-87.

Each group contributed two to four goals, and several objectives for each goal. Action steps are listed for each of the objectives, along with information on the time frame for action.

Use this list of key words to find objectives that are similar, or that require collaboration and coordination. For example, adherence is mentioned in Health Objective 1B, Mental Health Objective 1B, and Social Services Objective 3B.

<b>Access</b>	AOD 1B Health 2B Social Services 1A	AOD 2B Housing 2B Social Services 1C	AOD 3A  Social Services 1D
<b>Adherence</b>	Health 1B	Mental Health 1B	Social Services 3B
<b>Cultural Competence/ Cultural Appropriateness</b>	AOD 1A	Social Services 1B	
<b>Housing</b>	AOD 2A Housing 1A Housing 2C	AOD 2B Housing 2A Housing 3A	Housing 2B
<b>Information</b>	Infrastructure 1A	Social Services 2B	Social Services 3A
<b>Linkage/Integration</b>	AOD 4A Social Services 2A	Health 2C	Mental Health 2B
<b>Training and Technical Assistance</b>	Infrastructure 2A Social Services 1B	Mental Health 2B Social Services 3A	Social Services 3B
<b>Quality/Standards</b>	Health 3A Infrastructure 2A	Health 3B Mental Health 1A	Housing 3A Social Services 4B
<b>Welfare/Special Need Plans (SNPs)</b>	Health 4A Social Services 3A	Health 4B Social Service 3C	

## Key to symbols

Time frames are indicated using the three symbols below. The numeral "1" means Year 1, "2" means Year 2, "3" means Year 3.



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When necessary, a comment section appears below the action steps. Similar objectives from other Work Groups, or information about other responsible parties that need to be involved are listed.

**AOD  
Work Group  
in New  
York City**

**Goal 1: Improve the health of AOD users.**

**Objective 1A: Health care, mental health and other providers will provide culturally and linguistically appropriate and sensitive services to AOD users.**

Action steps: **1 2** Initially, work with AOD users from the PWA Advisory Group and later develop a template to fund consumer focus groups. Use input to define “health” and “mental health” from the perspective of AOD users. Incorporate into AOD templates. Consider additional uses (e.g., as the basis for provider and consumer training and/or the development of an AOD provider manual).

Comments: Discussions with AOD users from the PWA Advisory Group and implementation of consumer focus groups are only mentioned under AOD objective 1A. However, these discussions would be used to glean valuable information with relevance to all of the AOD objectives. A document, entitled AOD Focus Group Initiative, has been drafted; it details the specific goals and topics to be covered during focus groups. This document can be accessed through the chair of the AOD Work Group. For other objectives that involve cultural appropriateness and cultural competence, see Social Services Objective 1B.

**Objective 1B: Health care, mental health, and other services will be more accessible to AOD users.**

Action steps: **1 2 3** Allocate resources to provide health care and mental health services at AOD service delivery sites.

**1** Advocate for the elimination of abstinence as a requirement for health and mental health services utilization by incorporating this requirement into all templates from all Work Groups.



**1** Advocate for the release of inmates during the workday to help ensure immediate access to needed services.

Comments: For other objectives that involve access, see AOD Objectives 2B and 3A, Health Objective 2B, Housing Objective 2B, and Social Services Objectives 1A, 1C, and 1D.

**Goal 2: Improve the housing stability of AOD users.**


**AOD  
Work Group  
in New  
York City**

**Objective 2A: Safe, stable, low threshold housing will be available to AOD users.**

- Action steps:
-  Advocate for the maintenance of housing when AOD users are in treatment and for the elimination of abstinence as a requirement for receipt or continuation of housing by incorporating this requirement into all templates from all Work Groups.
  -  Collaborate on a new low-threshold housing template for AOD users, which includes the needs of recent prison releasees.

Comments: Collaborate with the Housing Work Group to achieve these action steps. Comments: For other objectives that involve housing, see AOD Objective 2B, and Housing Objectives 1A, 2A, 2B, 2C, and 3A.

**Objective 2B: AOD users will have access to a broad continuum of services that are comprehensively integrated into the range of housing settings.**

- Action steps:
-  Collaborate with the Housing Work Group to incorporate focus group findings (see AOD objective 1A) into future priority setting and resource allocation decisions.

Comments: For other objectives that involve access, see AOD Objectives 1B and 3A, Health Objective 2B, Housing Objective 2B, and Social Services Objectives 1A, 1C, and 1D.

**Key to Symbols**



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**AOD  
Work Group  
in New  
York City**

**Goal 3: Reduce AOD-related harm.**

**Objective 3A: AOD users will have access to a high quality continuum of services, including low threshold/harm reduction services, upon demand.**

Action steps:

**1**

Advocate to the legislature for overdose legislation, approval of buprenorphin treatment as an alternative to methadone, and study of the option to allow psychologists to dispense medication.

**1/2  
3**

Investigate the availability of AOD services in zip codes found to have high rates of HIV co-morbidity. Target AOD services accordingly, making sure that the full range of desired services are available (including harm-reduction services).

**1 2 3**

Allocate resources designed to assist the transition of prison releasees back into the community, e.g. escort/follow-up workers.

Comments:

Collaborate with the Policy Committee to achieve advocacy-related actions. For other objectives that involve access, see AOD Objectives 1B and 2B, Health Objective 2B, Housing Objective 2B, and Social Services Objectives 1A, 1C, and 1D.

**Goal 4: Ensure the effective communication, coordination, and collaboration among consumers and service providers.**

**Objective 4A: Provider-to-provider and provider-to-consumer communications will be appropriate, effective, and confidential.**

Action steps:

**1**

Advocate for the clarification of drug and HIV-related confidentiality procedures such that regulations promote effective communication while maintaining the right to privacy.





Comments:

Collaborate with the Policy Committee to achieve this action. For other objectives that involve linkage and integration, see Health Objective 2C, Mental Health Objective 2B, and Social Services Objective 2A.





**Goal 1: Ensure that people with HIV achieve and maintain optimal health and well being.**

**Health Services  
Work Group  
in New  
York City**

**Objective 1A: Persons with HIV disease engaged in health care services will have improved survival and health outcomes.**

- Action steps:
-  Gather and analyze data on survival and health outcomes.
  -  Identify models of comprehensive primary care that maximizes improved survival and health outcomes.
  -  Allocate resources to specific populations and geographic communities where necessary.
  -  Promote referral to expanded access HIV treatment protocols and clinical trials.

**Objective 1B: Persons with HIV disease who receive health services will adhere to treatments.**

- Action steps:
-  Gather and analyze data on adherence.
  -  Identify models of treatment adherence.
  -  Allocate resources for adherence training and education for providers and consumer.
  -  Allocate resources to support treatment adherence.

Comment: For other objectives that involve adherence, see Mental Health Objective 1B and Social Services Objective 3B.

**Key to Symbols**



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**Health Services  
Work Group  
in New  
York City**

**Goal 2: Provide access to care for people with HIV disease throughout the EMA.**

**Objective 2A: Persons with HIV disease engaged in care will remain connected to services once they have entered the continuum of care.**

- Action steps:
-  Gather and analyze data maintenance in care.
  -  Identify models of maintenance in care programs.
  -  Allocate resources to maintenance in care programs.




**Objective 2B: Persons with HIV who are unconnected to care will access the continuum of care.**

- Action steps:
-  Gather and analyze data on persons unconnected to care and barriers to accessing care.
  -  Identify models of reaching persons unconnected to care and bringing them into care.
  -  Allocate resources to access to care programs.

Comment: For other objectives that involve access, see AOD Objectives 1B, 2B, 3A, Housing Objective 2B, and Social Services Objectives 1A, 1C, and 1D.

**Health Services  
Work Group  
in New  
York City**

**Objective 2C: Services across the continuum of care from outreach through long-term care will be linked and integrated.**

- Action steps:
-  Gather and analyze data on service linkage and integration.
  -  Identify policies and methods to enhance service linkage and integration.
  -  Allocate resources to support service linkage and integration.

Comment: For other objectives that involve linkage, see also AOD Objective 4A, Mental Health Objective 2B, and Social Services Objective 2A.

**Key to Symbols**



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**Goal 3: Ensure that HIV care and services are high quality.**


**Objective 3A: Persons with HIV disease in care receive services that meet or exceed the quality standards of the New York State AIDS Institute.**


- Action steps:
-  Provide input to the AIDS Institute on development of quality standards.
  -  Gather and analyze data on quality of care and services.
  -  Allocate resources to enhance quality care and services.

Comments: For other objectives that involve quality and standards, see Health Objective 3B, Housing Objective 3A, Infrastructure Objective 2A, Mental Health Objective 1A, and Social Services Objective 4B. The New York State Department of Health AIDS Institute Title I Quality Management Program is described in detail in Chapter 3.

**Health Services  
Work Group  
in New  
York City**

**Objective 3B: Persons with HIV disease in care report their health-related quality of life as “good” or better.**


Action steps:  Gather and analyze data on health-related quality of life reports of persons with HIV disease in care.


 Allocate resources to improve health-related quality of self-life reports of persons with HIV disease in care.

Comment: For another objective that involves quality of life, see Mental Health Objective 1C.

**Goal 4: Respond to changes in publicly financed HIV care and services.**


**Objective 4A: The Planning Council will receive timely information on the impact of major external changes affecting the continuum of care.**


Action steps:  Gather and analyze data on major external changes affecting the continuum of care.

 Allocate resources as necessary to respond to new needs resulting from changes in the external environment.

Comment: For other objectives that involve the changing environment, see Health Objective 4B (SNPs), and Social Services Objectives 3A (SNPs) and 3C (welfare reform).

**Objective 4B: The Planning Council will take action to address new demands on the continuum of care, such as full implementation of Special Needs Plans (SNPs).**

Action steps:  Gather and analyze data on the full implementation of SNPs.

 Allocate resources as necessary to respond to new needs resulting from full implementation of SNPs.

Comment: For other objectives that involve the changing environment, see Health Objective 4A, and Social Services Objectives 3A (SNPs) and 3C (welfare reform).

**Housing  
Work Group  
in New  
York City**

**Goal 1: Increase the volume of housing units that are appropriate for people with HIV/AIDS.**





**Objective 1A: Transitional housing will be available to people with HIV/AIDS who need it.**

- Action steps:
-  Identify populations in need of transitional housing.
  -  Identify appropriate models of housing.
  -  Identify financing sources to implement these models.
  -  Recommend evaluation of existing housing models.
  -  Allocate resources to increase the availability of transitional housing.

Comments: Additional responsible parties include HASA, MHRA, and provider networks. For other objectives that involve housing, see AOD Objectives 2A and 2B.

**Goal 2: Expedite access to existing housing and provide supportive services for people with HIV/AIDS.**

**Objective 2A: Housing placement assistance services will be available for persons with HIV disease who need it.**

- Action steps:
-  Develop standards for housing placement assistance programs.
  -  Identify populations in need of housing placement assistance.
  -  Identify appropriate service models.
  -  Advocate for funding to launch new and improve existing Housing Placement Assistance programs.

Comments: For other objectives that involve housing, see AOD Objectives 2A and 2B. Additional responsible parties include HASA, MHRA, and provider networks.

**Key to Symbols**



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**Housing  
Work Group  
in New  
York City**

**Objective 2B: Persons with HIV disease who need housing-related supportive services will have them.**





Action steps:

-  Identify populations who need housing-related supportive services.
-  Identify alternative models of housing-related supportive services for target populations.
-  Identify supportive services appropriate for people with HIV disease using non-CARE Act funding.
-  Assist in the development of referral mechanisms to access non-CARE Act funded supportive services.

Comments: Other responsible parties include HIV/AIDS Services Administration (HASA), Postgraduate Center for Mental Health (PCMH), Hudson Planning Group. For other objectives that involve access, see Health Objective 2B, AOD Objectives 1B, 2B, 3A, and Social Services Objectives 1A, 1C, and 1D. For other objectives that involve housing, see AOD Objectives 2A and 2B.

**Objective 2C: Emergency rental assistance will be available to people with HIV/AIDS who need it.**

Action steps:



-  Identify populations in need of emergency rental assistance.
-  Identify additional financing sources for emergency financial assistance.
-  Assist in the development of incentives for landlord participation in providing emergency financial assistance.
-  Identify and develop a strategy to reduce barriers to timely dispersal of funds.

Comments: Other responsible parties include HASA, PCMH, Hudson Planning Group. For other objectives that involve housing, see AOD Objectives 2A and 2B.

**Goal 3: Improve the quality of housing in which people with HIV/AIDS are living.**

*Housing  
Work Group  
in New  
York City*

**Objective 3A: Housing and/or housing-related services for persons with HIV/AIDS will be appropriate and of high quality.**




- Action steps:
-  Collaborate on the development of technical assistance for CARE Act-funded providers.
  -  Collaborate on the development of training for non-AIDS providers delivering housing and housing-related services to clients with HIV/AIDS.

Comments: Other responsible parties include HASA, PCMH, Hudson Planning Group, Technical Assistance Providers. For other objectives that involve housing, see AOD Objectives 2A and 2B. For other objectives that involve quality and standards, see Health Objectives 3A and 3B, Infrastructure Objective 2A, Mental Health Objective 1A, and Social Services Objective 4B.

**Goal 1: Empower people with HIV to make informed personal health choices and assist providers in delivering quality HIV services.**

*Infrastructure  
Work Group  
in New  
York City*






**Objective 1A: Appropriate information will be available on type and location of services and on options for choosing services that best meet the needs of persons with HIV.**

- Action steps:
-  Ensure availability of information to the largest possible audience.
  -  Promote marketing, training, and education of the information resource to people living with HIV and providers.
  -  Evaluate the EMA's information resource program.

Comment: For other objectives that involve information resources, see Social Services Objectives 2B and 3A.





**Infrastructure  
Work Group  
in New  
York City**

**Objective 1B: Persons with HIV disease will provide meaningful input to HIV/AIDS service organizations on program design, implementation, and evaluation.**

- Action steps:
-  Identify models for Consumer Advisory Boards.
  -  Set guidelines and standards for CABs.
  -  Promote marketing and education on CABs.
  -  Evaluate the effectiveness of CABs.
  -  Allocate resources for CAB-related training and technical assistance.


**Goal 2: Strengthen the continuum of care for persons with HIV by building the capacity of service providers.**

**Objective 2A: Providers will access and use appropriate outcome-based technical assistance to improve the quality and reach of their services.**

- Action steps:
-  Gather and analyze data on the need for and effectiveness of technical assistance.
  -  Identify models of technical assistance that are outcome based.
  -  Promote marketing of technical assistance.
  -  Allocate resources to support technical assistance.

Comment: For other objectives involving training and technical assistance see Mental Health Objective 2B and Social Services Objectives 1B, 3A, and 3B.

**Objective 2B: Providers will deliver services that reflect the meaningful input of consumers they serve.**


Action steps:  Gather and analyze data from consumers on their experiences with providing input.


Comment: Also see action steps above for Objective 1B.


**Infrastructure  
Work Group  
in New  
York City**


**Goal 1: Ensure a continuum of appropriate, high quality mental health care and services.**


**Objective 1A: Persons with HIV disease will receive mental health care and services that meet clinical and practice standards, achieving parity with other health care services.**

Action steps:  Collaborate on the development and dissemination of performance standards for the provision of high quality mental health services for people with HIV.

 Provide guidance to the grantee to assure that professional mental health services are provided by NYS licensed providers with appropriate experience, training, and ongoing supervision.

 Collaborate on the development of HIV-specific training, biannually at a minimum, for mental health professionals to address issues such as case finding, drug interactions, transitional planning, HIV treatment updates, and adherence.

 Provide guidance to the grantee that leads to mechanisms ensuring that standards of care and service guidelines are met.

 Recommend continuation of studies on existing and emerging issues to ensure proper planning regarding their impact on mental health care.

Comments: For other objectives that involve adherence, see Health Objective 1B and Social Services Objective 3B. For other objectives that involve quality and standards, see Health Objectives 3A and 3B, Housing Objective 3A, Infrastructure Objective 2A, and Social Services Objective 4B.

**Mental Health  
Work Group  
in New  
York City**

**Mental Health  
Work Group  
in New  
York City**

**Objective 1B: Persons with HIV disease engaged in mental health care and services will adhere to treatment.**

Action steps:



Collaborate on the development of adherence guidelines that define and expand the role of mental health treatment in promoting adherence.



Collaborate on the development of training for health care providers to better understand and define the role of mental health in enhancing all aspects of medical adherence.



Allocate resources to support service models that promote adherence through co-located and/or linked health and mental health services. Provide appropriate guidance to the grantee.



Recommend a study to determine the effects of mental health functioning on adherence.

Comment:

For other objectives that involve adherence, see Health Objective 1B and Social Services Objective 3B.

**Objective 1C: Persons with HIV disease engaged in mental health care and services will have improved quality of life.**

Action steps:



Recommend studies to develop quality of life measures and standards that are sensitive to the diverse population of individuals living with HIV.



Participate in the development of quality of life measures into clinical and practice standards.





Comment:

For another objective that involves quality of life, see Health Objective 3B.



**Goal 2: Facilitate access, engagement, and retention in care by providing integrated mental health care and services.**

**Mental Health  
Work Group  
in New  
York City**

**Objective 2A: Persons with HIV disease will receive appropriate assessments for mental health needs.**

- Action steps:
-  Identify a mental health assessment protocol that can be used across all disciplines within the HIV services arena to assure proper referrals. Provide guidance to the grantee requiring use of the protocol in contract service provisions.
  -  Provide guidance to the grantee requiring all people with HIV disease in care receive a global assessment of bio/psycho/social/spiritual needs in all service settings at program entry, quarterly, and as clinically indicated.
  -  Recommend continuation of study of existing and emerging special populations to ensure engagement into care and proper planning efforts with regard to mental health services.
  -  Allocate resources to address service gaps and needs of special populations.

**Objective 2B: Persons with HIV disease will receive mental health services that are linked and integrated with health care and other supportive services to promote retention in care.**

- Action steps:
-  Collaborate on the development of training and technical assistance to help providers create comprehensive service programs that network and link primary care, social services, housing, AOD and mental health.
  -  Allocate resources in support of service models in primary care/health, social service, AOD and housing settings that co-locate and/or link to professional mental health services.

Comments: For other objectives that involve linkage and integration, see AOD Objective 4A, Health Objective 2C, and Social Services Objective 2A. For other objectives that involve training and technical assistance, see Infrastructure Objective 2A and Social Services Objectives 1B, 3A, and 3B.

**Key to Symbols**



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**Social Services  
Work Group  
in New  
York City**


**Goal 1: Provide a comprehensive range of available and accessible HIV-related social service programs.**


**Objective 1A: People living with HIV disease will have local access to case management services.**

Action steps:  Continue CHAIN mapping and service gaps research. Use these data to identify under-served geographic regions and special populations. Target services to high-need areas as appropriate.

Comments: Include immigrants, people over 50, and the hearing and/or visually impaired. For other objectives that involve access, see Social Services Objectives 1C and 1D, Health Objective 2B, Housing Objective 2B, and AOD Objectives 1B, 2B, and 3A.


**Objective 1B: People living with HIV disease will have access to culturally competent and linguistically appropriate social services.**

Action steps:  Provide guidance to the grantee to assure provider cultural competency training in contract service provisions.

 Collaborate on the development of cultural competency training.

Comments: Collaborate with the Infrastructure Work Group on the development of cultural competency training. For other objectives that involve cultural appropriateness and cultural competence, see AOD Objective 1A. For other objectives that involve training and technical assistance, see Infrastructure Objective 2A and Social Services Objectives 1B, 3A, and 3B.


**Objective 1C: People living with HIV disease will have access to necessary transportation services.**

Action steps:  Add evaluation component to future transportation allocations recommendations. Evaluate effectiveness of alternative transportation service models. Adjust future transportation allocations as appropriate, based on evaluation results.

Comment: For other objectives that involve access, see Social Services Objectives 1A and 1D, Health Objective 2B, Housing Objective 2B, and AOD Objectives 1B, 2B, and 3A.

**Social Services  
Work Group  
in New  
York City**


**Objective 1D: People living with HIV disease will have access to a broad range of support, advocacy, and basic needs programs within their geographic area.**

Action steps:  Continue mapping and service gaps research. Use these data to identify under-served geographic regions and special populations. Target services to high-need areas as appropriate.

Comments: Include immigrants, people over 50, and the hearing and/or visually impaired. For other objectives that involve access, see Social Services Objectives 1A and 1D, Health Objective 2B, Housing Objective 2B, and AOD Objectives 1B, 2B, and 3A.


**Goal 2: Ensure effective communication, coordination, and collaboration among social services, medical, housing, and other service providers.**


**Objective 2A: Linkages will be improved among social service, medical, mental health, substance abuse, food and nutrition, case management, housing, and legal service agencies.**

Action steps:  Provide guidance to the grantee requiring that MHRA regularly monitor and report on case management and ambulatory care referral arrangements.

Comment: For other objectives that involve linkage and integration, see AOD Objective 4A, Health Objective 2C, and Mental Health Objective 2B.

**Objective 2B: Ensure effective dissemination of information about available services and program updates in each borough.**

Action steps:  Recommend the Planning Council collaborate with the AIDS Institute regarding (1) the usefulness of Title II networks as currently configured, and (2) alternatives/improved approaches to achieving the tasks and outcomes currently assigned to the networks.

 Recommend to the Planning Council development of an Internet-based resource database for Title I service providers.

Comments: The AIDS Institute is another involved party. For other objectives that involve information and referral, see Social Services Objective 3A and Infrastructure Objective 1A.

**Key to Symbols**



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**Social Services  
Work Group  
in New  
York City**

**Goal 3: Ensure that people living with HIV disease have access to the knowledge, skills, and assistance necessary for them to successfully navigate and utilize services within a changing service delivery system.**

**Objective 3A: People living with HIV disease will have adequate knowledge regarding managed care and Special Needs Plans (SNPs).**

- Action steps:
- 1** Provide guidance to the grantee to assure social services provider training on changes in managed care and SNPs in contract service provisions.
  - 1 2 3** Collaborate on the development and distribution of consumer education materials on managed care and SNPs.

Comments: Collaborate with the Health Services and Infrastructure Work Groups regarding SNP educational materials. For other objectives that involve information and referral, see Social Services Objective 2B and Infrastructure Objective 1A. For other objectives that involve the changing environment, see Health Objectives 4A (financing) and 4B (SNPs), and Social Services Objective 3C (welfare reform). For other objectives that involve training and technical assistance, see Infrastructure Objective 2A, Mental Health Objective 2B, and Social Services Objectives 1B, 3A, and 3B.



**Objective 3B: People living with HIV disease will have adequate knowledge regarding treatment issues and adherence strategies.**

- Action steps:
- 1** Recommend pilot testing of treatment education and adherence models in non-medical settings.
  - 1** Provide guidance to the grantee to assure social services provider training on treatment issues and adherence strategies in contract service provisions.

Comments: For other objectives that involve adherence, see Health Objective 1B and Mental Health Objective 1B. For other objectives that involve training and technical assistance, see Infrastructure Objective 2A, Mental Health Objective 2B, and Social Services Objectives 1B, 3A, and 3B.

**Social Services  
Work Group  
in New  
York City**



**Objective 3C: HIV/AIDS service providers will respond to welfare reform with a focus on ensuring that the basic needs of people living with HIV disease are met.**

- Action steps:
-  Recommend assessment of the impact of welfare reform on persons living with HIV disease.
  -  Address policy barriers that prevent providers from responding effectively to the loss of government safety net programs.



Comment: For other objectives that involve the changing environment, see Health Objectives 4A (financing) and 4B (SNPs), and Social Services Objective 3A (SNPs).

**Goal 4: Ensure the delivery of high quality social services.**

**Objective 4A: People living with HIV disease who are eligible will receive the maximum benefits to which they are entitled.**

- Action steps:
-  Provide guidance to the grantee to assure social services provider training on the full range of entitlement programs and eligibility requirements in contract service provisions.
  -  Recommend that the Planning Council establish a routine communication mechanism between HASA and AIDS service providers, including direct participation of HASA on the Social Services Work Group.

**Objective 4B: HIV/AIDS service providers will adhere to standards of care.**

- Action steps:
-  Participate in the development and adoption of performance standards being developed by the Title I Quality Management Program in coordination with the AIDS Institute.
  -  Adopt existing AIDS Institute case management services standards of care and monitor adherence.

Comment: For other objectives that involve quality and standards, see Health Objectives 3A and 3B, Housing Objective 3A, Infrastructure Objective 2A, and Mental Health Objective 1A.

**Key to Symbols**



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**Tri-County  
Region**

**Goal 1: Maintain and enhance access to, and ensure a comprehensive continuum of care for, all Tri-County residents living with HIV/AIDS, especially disproportionately affected populations.**

**Objective 1A: Clients and providers will know what to do to access the services they need.**

- Action steps:
-  Conduct ongoing education that informs clients/providers about HIV services available and how/where they can be accessed.
  -  Develop an online, Tri-County-based HIV information network/website.
  -  Develop a user-friendly updated resource directory that corresponds with website.
  -  Identify and support innovative community education models, which include HIV treatment, care, and prevention.







**Objective 1B: Clients will receive the standard of care that meets or exceeds the New York AIDS Institute standards.**

- Action steps:
-  Adhere to AIDS Institute standards of care.
  -  Participate in the development of quality standards as part of the Title I Quality Management (QM) Program.
  -  Continually assess and respond to gaps in the continuum of care identified by the QM/standards process.

**Tri-County  
Region**

**Objective 1C: Clients will be linked to appropriate services through improved communication, coordination and referral among HIV/AIDS service providers and related agencies.**

Action steps:

-  Develop and implement improved communication process/systems among providers, including interagency/ multidisciplinary meetings.
-  Encourage linkages between HIV/AIDS service providers and related agencies.
-  Recommend agencies have access to the Internet to determine best services for clients.
-  Organize provider presentations at Title II Network meetings.
-  Create a Tri-County-specific, comprehensive client needs assessment tool and train staff in its use.
-  **1** Revise Tri-County HIV Resource Guide and include a section entitled, "What to do now that you've tested HIV+." Make guide available in both text and electronic format.

**Key to Symbols**



This action step is a continuation of an ongoing and existing process or activity. Activities related to this action step can occur at any time during the year.



This action step is a new ongoing activity that occurs in the year or years indicated. In this example, the action begins in year 1 and recurs in year 2 and year 3.



This action step is a discrete activity that occurs at a particular time during the year or years indicated. In this example, the action is in year 2.

**Tri-County  
Region**

**Objective 1D: Persons with HIV/AIDS will receive appropriate housing and related services in the Tri-County region.**

- Action steps:
- 1** Determine and prioritize range of housing needs of persons living with HIV disease in Tri-County.
  - 1** Identify/develop housing models to meet needs of homeless persons living with HIV disease in Tri-County.
  - 1 2 3** Allocate resources to meet priority needs.
  - 1/2/3** Enhance existing housing assistance services to include community education of housing and related services.
  - 1** Develop databank and/or hotline of affordable housing for clients.
  - 1/2/3** Advocate for rent subsidies to help stabilize in-need households and move them toward self-sufficiency.

**Objective 1E: Assure a comprehensive continuum of care for HIV/AIDS services needed by people with HIV/AIDS in the Tri-County region.**

- Action steps:
- 1** Conduct a needs assessment to identify gaps and unmet needs of people living with HIV disease.
  - 1** Identify service models and plan programs.
  - 1 2 3** Allocate resources to implement model programs.
  - 1/2/3** Reassess and modify programs as needs and environment change.

**Goal 2: Bring those individuals who know their HIV-positive status, but are not yet in care, into the medical and supportive services system.**

**Objective 2A: The number of individuals who know their status and are not engaged in care will be identified as well as reasons why they are not in care.**

Action steps: Review Tri-County-specific CHAIN study regarding reasons why people delay accessing services.

**Objective 2B: People who know their status will be educated and informed about appropriate service options.**

Action steps: Allocate resources to fund agencies to deliver educational sessions on HIV care and treatment to consumers and providers.

Conduct a consumer-focused needs assessment to determine education and service needs of consumers.

Provide education to non-HIV providers and at-risk people that addresses distrust of the medical establishment and treatments for HIV disease.

Provide culturally and linguistically appropriate educational materials and information regarding HIV testing and other services.

**Key to Symbols**



This action step is a continuation of an ongoing and existing process or activity. Activities related to this action step can occur at any time during the year.






This action step is a new ongoing activity that occurs in the year or years indicated. In this example, the action begins in year 1 and recurs in year 2 and year 3.



This action step is a discrete activity that occurs at a particular time during the year or years indicated. In this example, the action is in year 2.

**Tri-County  
Region**

**Objective 2C: People who know their status and are not in care will be engaged through linked and coordinated services across the continuum of care.**




- Action steps:
-  Develop outreach programs to engage at-risk populations.
  -  Develop outreach programs that reconnect people who were in care but are not currently engaged.
  -  Develop a provider network that establishes linkages among providers.

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**Goal 3: Engage individuals who are unaware of their HIV-positive status and bring them into the medical and supportive services system.**



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**Objective 3A: Persons with HIV disease who do not know their HIV-positive status will choose to know their status and seek care.**

- Action steps:
-  Provide education to non-HIV providers and at-risk people that addresses distrust of the medical establishment and treatments for HIV disease.
  -  Provide culturally and linguistically appropriate educational materials and information regarding HIV testing and other services.
  -  Provide access to counseling and testing services and connect HIV-positive persons to coordinated services.
-

**Tri-County  
Region**

**Objective 3B: At-risk populations and their service providers will be educated about how to bring persons with HIV who do not know their status into testing and medical care.**

- Action steps:
-  Develop outreach programs for caregivers and families.
  -  Develop a mobile outreach and testing program that operates outside of the regular workday and visits locations in the region that are known to be places where hard-to-reach populations are found.

**Key to Symbols**



This action step is a continuation of an ongoing and existing process or activity. Activities related to this action step can occur at any time during the year.



This action step is a new ongoing activity that occurs in the year or years indicated. In this example, the action begins in year 1 and recurs in year 2 and year 3.



This action step is a discrete activity that occurs at a particular time during the year or years indicated. In this example, the action is in year 2.

## C. Data and Policy Goals and Objectives

The CARE Act mandates eight responsibilities for each Title I Planning Council. The New York Planning Council’s management process assures these and other roles are fulfilled.


This section presents goals and objectives that focus on two specific areas of the Planning Council’s functioning:

- Developing data to support Planning Council decision-making.
- Developing policies to contribute to the health and quality of life of people living with HIV disease.




**Data  
Goals and  
Objectives**

**Goal: Provide data, for the purposes of planning, on the needs of persons with HIV, trends in the external environment that affect them, and other relevant information.**

**Objective 1A: A comprehensive and accessible resource of recent local, State, and Federal planning data will be available.**




Action steps:  Develop and maintain a resource library of local, State, and Federal planning data.

**Objective 1B: The resource library will be used by the EMA for annual updates to the strategic plan, and for annual resource allocation, implementation, and evaluation.**

Action steps:  Use the resource library for the annual update of this plan.  
 Use the resource library for the annual priority setting and resource allocation process.  
 Use the resource library for setting priorities for new evaluation initiatives.



**Data  
Goals and  
Objectives**

**Objective 1C:** The strategic plan's goals and objectives will be measured and reported to the appropriate parties at least once a year.


- Action steps:
-  Gather and analyze data necessary to measure the plan's goals and objectives.
  -  Develop a work plan of activities to assure that measuring the plan is ongoing and timely.
  -  Develop and report annually updates of the plan.

**Goal 2: Enhance knowledge of the distribution and utilization of health and human services for persons with HIV and promote better understanding of the impact of those services.**

**Objective 2A:** Distribution and utilization data for Title I services will be timely, descriptive, complete, and accurate.

- Action steps:
-  Develop data requests and initiatives that respond to priority planning questions and tasks.
  -  Disseminate new data reports on distribution and utilization data.

**Objective 2B:** Client-level data for planning and program development will be available from an EMA-wide comprehensive information management system.

- Action steps:
-  Develop a mechanism to report unduplicated client-level data incorporating Title I and Title II.

**Key to Symbols**



This action step is a continuation of an ongoing and existing process or activity. Activities related to this action step can occur at any time during the year.



This action step is a new ongoing activity that occurs in the year or years indicated. In this example, the action begins in year 1 and recurs in year 2 and year 3.



This action step is a discrete activity that occurs at a particular time during the year or years indicated. In this example, the action is in year 2.


**Data  
Goals and  
Objectives**

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**Goal 3: Identify and address gaps in knowledge regarding the health and human service needs of persons with HIV.**


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**Objective 3A: Gaps in knowledge regarding the needs of communities, specific populations, and emerging trends affecting persons with HIV will be identified and prioritized.**

Action steps:  Develop data requests to fill gaps in knowledge regarding needs of geographic communities, specific populations, and emerging trends.

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**Objective 3B: Ongoing and special studies related to gaps in knowledge will be developed and their results integrated into planning and priority setting.**

Action steps:  Develop ongoing and special studies to address gaps in knowledge.




 Disseminate findings from these studies to the appropriate planning groups and processes.

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**Goal 1: Develop Planning Council policies that contribute to the health and quality of life of persons with HIV in the New York EMA.**

*Policy Goals and Objectives*

**Objective 1A: Key policy issues will be monitored, analyzed, and reported to the Planning Council and others as appropriate.**

- Action steps:
-  Develop mechanisms to monitor, analyze, and report on key policy issues.
  -  Develop a work plan for establishing policy positions and action steps related to Federal CARE Act annual appropriations and 2005 reauthorization.
  -  Provide input to draft reports and presentations prepared for the Planning Council and its Work Groups.

Comments: The work plan should describe the policy issues (e.g. CARE Act appropriations and reauthorization, immigration, SNPs, welfare reform). A range of specific actions that can be undertaken should be indicated (e.g. letter writing, endorsing actions, advocacy with key stakeholders). The policy plan should clarify who has the authority to represent the Planning Council and under what circumstances. It should clarify the policy role of individual members of the Planning Council, as well as Work Group and Committee members. Specific housing-related policy issues to be examined include increasing Federal, State, and local appropriation for HIV/AIDS housing, redirecting HOPWA funds, capital development policies and procedures, economic incentives for property owners, and HASA efficiency, referral policy, benefit policy, and adherence to Local Law 49.

**Key to Symbols**



This action step is a continuation of an ongoing and existing process or activity. Activities related to this action step can occur at any time during the year.



This action step is a new ongoing activity that occurs in the year or years indicated. In this example, the action begins in year 1 and recurs in year 2 and year 3.






This action step is a discrete activity that occurs at a particular time during the year or years indicated. In this example, the action is in year 2.

**Policy  
Goals and  
Objectives**

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**Objective 1B: Policy positions will be developed with input from the community and from outside experts where needed.**

- Action steps:
-  Coordinate policy development with other key policy, planning, and advisory bodies.
  -  Implement mechanisms (such as public forums) seeking input from the community.
  -  Obtain input from outside experts on policy issues where appropriate.

Comments: Groups that require collaboration include PWA Advisory Group, the New York City Prevention Planning Group, AIDS Institute, and NYCDOH.

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**Objective 1C: Policy positions that are adopted will be acted upon through coordinated community-based and national advocacy.**

- Action steps:
-  Implement action steps related to policy positions.
  -  Evaluate effectiveness of action steps that are implemented.
-



**Goal 2: Ensure community input and collaboration on Title I policy and planning.**

**Policy  
Goals and  
Objectives**

**Objective 2A: Community input to the Planning Council's policy and planning activities, including priority setting, will be meaningful, consistent, and timely.**

- Action steps:
-  Obtain community input on planning and priority setting.
  -  Evaluate and report community input.

**Objective 2B: Policy and planning decisions will reflect coordination and collaboration within the Title I planning process and outside it where possible.**

- Action steps:
-  Coordinate and collaborate policy and planning decision-making with appropriate parties.
  -  Evaluate coordination and collaboration of policy and planning decision-making.

**Key to Symbols**



This action step is a continuation of an ongoing and existing process or activity. Activities related to this action step can occur at any time during the year.



This action step is a new ongoing activity that occurs in the year or years indicated. In this example, the action begins in year 1 and recurs in year 2 and year 3.



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## Monitoring and Evaluation: How Will We Monitor Our Progress?

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This chapter presents a framework for monitoring and evaluating this plan. In preparing the monitoring component, the Planning Council sought to achieve three goals:

- To provide a mechanism by which the Planning Council can measure progress toward achievement of the plan's goals and objectives and develop an annual work plan of activities.
- To identify areas for data collection to assist the Planning Council (especially the Planning and Evaluation Committee) in targeting planning funds for evaluation-related activities.
- To provide direction to the Grantee and its Master Contractor in the process of targeting, measuring, and achieving outcomes of services supported by Title I funds in 2002-2005.

### A. Context for Monitoring and Evaluation

Performance monitoring and evaluation activities are vital to pursuing the vision set forth in this plan. However, monitoring does not occur in a vacuum. A number of factors should be taken into consideration when judging performance over time.

**The changing environment.** It is difficult to know for certain how recent or future changes in entitlement and immigration laws, as well as clinical advances, will affect people with HIV disease. Growth of future levels of Federal funding is uncertain. These uncertainties affect planning and priority setting, and also complicate the selection of performance indicators and measures. As more information becomes available to the Planning Council, the appropriate indicators (and their measures) can be refined.

An **indicator** is a statement that defines success for a given objective.

A **measure** is a specific factor or variable that can be measured to indicate progress in achieving an objective.

**Data limitations.** Several types of data limitations affect the Planning Council’s ability to monitor strategic plan performance. These include:

- A general lack of baseline or comparison data against which to judge performance. Data from the CHAIN study is frequently relied on in this plan to provide baseline data. However, the cohort is limited to people living with HIV/AIDS in New York City who are in care. (In 2002, CHAIN is expanding to the Tri-County region and the New York City cohort is being refreshed.) Other studies may be identified in the future to provide data on persons not in care in the EMA.
- In an era of constrained resources, the ability to collect new evaluation data is limited.
- Historically, monitoring and evaluation of Title I services has primarily involved process evaluation (e.g., Were intended Work Group activities completed?) versus outcome evaluation (e.g., Were desired programmatic outcomes achieved?). Meanwhile, HRSA and other funders increasingly emphasize the need to collect and analyze outcomes data.

## B. Criteria and Process for Selecting Performance Measures

The framework for monitoring the 2002-2005 plan is based on an outcomes-oriented approach. Toward that end, and bearing in mind the data limitations outlined previously, the following prioritized list of outcome selection criteria were developed to aid in determining which measures to include in the current plan.

Criteria	Related Questions
<p>Priority will be given to measures for which needed data are already available on a routine basis, or can easily be made available on a routine basis with little cost and/or minimal effort.</p>	<ul style="list-style-type: none"> <li>• If data are already being collected: How frequently? Is funding for data collection secure for the next three years? How long does it take for results to be made available?</li> <li>• If data are not already being collected: How expensive and difficult would it be to implement data collection? How likely is it that funding for data collection will be available for the next three years? How long would it take for results to be made available?</li> </ul>

Criteria	Related Questions
<p>Priority will be given to measures that are defensible from a technical perspective.</p>	<ul style="list-style-type: none"> <li>• In terms of validity: Does this indicator truly measure what it was intended to measure?</li> <li>• In terms of reliability: To what extent is this measure likely to yield consistent results over time?</li> <li>• Is the entire population being measured or a sample? If a sample, is there reason to believe it is representative?</li> <li>• Is the sample size large enough to be acceptable from a statistical perspective?</li> </ul>
<p>Priority will be given to measures in the following order:</p> <ol style="list-style-type: none"> <li>1. Outcome measures (for example, improved health)</li> <li>2. Input or output measures (for example, number of individuals who enter a service)</li> <li>3. Process measures (for example, completion of a planned action item)</li> </ol>	<ul style="list-style-type: none"> <li>• Is there an alternative measure available from a higher category that could be used to determine success?</li> </ul>
<p>Priority will be given to measures where a strong argument can be made that the outcome is the “result of,” or at least “strongly influenced by,” Title I expenditures or other Planning Council initiatives.</p>	<ul style="list-style-type: none"> <li>• Is the “causal model” linking Planning Council activities to programmatic outcomes credible?</li> <li>• Are there major factors that contribute to this outcome that have little or nothing to do with Title I funding and/or other Planning Council activities?</li> <li>• Is it possible to compare the results for individuals receiving Title I services to the results for individuals not receiving Title I services?</li> </ul>

Goals, objectives, action steps, and initial measurement suggestions associated with the plan were generated during a series of meetings held with each Planning Council Work Group. During the final meeting, the characteristics of measures were discussed and potential measures were suggested for each objective. The plan's consultant team narrowed down the list generated by each Work Group using the criteria outlined above and, lastly, met with those responsible for the various data sources to finalize selection of at least one measure per objective.

## C. Data Sources Used to Monitor Plan Performance

Data sources cited in the monitoring and evaluation plan include those listed below. Note that each of these data sources has strengths and limitations. In several instances, changes in data collection methodologies and the data collected are expected to occur over the next year. These changes will require that the Planning Council revisit and potentially modify the framework for strategic plan monitoring at some point in the next 12 to 18 months.

**AIDS Surveillance Data.** These epidemiological data, derived from HIV/AIDS-related surveillance, are reported to the Planning Council on at least an annual basis by the New York City Department of Health. In the near future, New York State will report HIV infection data as well as AIDS data. At that point, the addition of outcome measures, utilizing these new data, should be considered.

**The CHAIN Study.** CHAIN is a longitudinal study of persons living with HIV disease in New York City. It is conducted on behalf of the Planning Council by Columbia University's School of Public Health. The study focuses on the impact of the entire HIV service system and not on Title I programs alone. The study assesses a variety of factors including client-reported health status, service utilization patterns, and satisfaction with services. Although the study's sample is one of the largest and most representative of people living with HIV ever followed in New York City, over time the sample has aged and become less representative due to attrition. During Summer 2002 Columbia will refresh the study cohort. This cohort will be followed over the coming years and will be compared and contrasted to the existing cohort. Once data are available from this new cohort, updated baselines will need to be inserted into the monitoring plan. In Summer 2002, CHAIN will begin collecting data from Tri-County residents. No baseline data are currently available for the Tri-County cohort.

**Program Monitoring Reports.** The Program Monitoring Report is specific to Title I activities. This report is prepared by the Medical and Health Research Association on an annual basis. It contains quantitative data on the clients served by Title I programs in New York City over the course of a particular year, and the types of services provided to Title I clients. At the time this plan was being prepared, the most recent report covered the period of March 2000 to February 2001.

## The New York State Department of Health AIDS Institute Title I Quality Management Program

In 2001, the AIDS Institute was awarded a contract through the Planning Council to measure the quality of health and supportive services provided under Title I. The AIDS Institute is currently in the process of developing performance measures for health, mental health, social services, alcohol and other drugs, and housing services. Formal decision-making methods are being employed in the process of indicator development to ensure the participation of consumers and provider agencies. Performance measurement at CARE Act Title I funded facilities will be phased in as the indicator development process has been completed.

Once indicator development is complete, these data should provide one of the best and most direct mechanisms for evaluating plan success. At that time, the framework for monitoring the plan should be revisited to include these new indicators as appropriate.

## D. Framework for Monitoring the Strategic Plan

### Guidelines for Using the Framework for Monitoring the Strategic Plan

The framework for monitoring the plan, outlined below, reiterates each goal and objective presented in Chapter 2. For most objectives, the following information is included in the framework:

- A measure, which is a specific factor or variable that can be measured to indicate progress in achieving the objective. For example, Objective 1A for the Health Work Group states, "Persons with HIV disease engaged in health care services will have improved survival and health outcomes." One of the success measures for this objective is the New York City HIV/AIDS mortality rate.
- Baseline data, which states the current status of the measure. For example, for the measure listed above, the baseline was "22:1,000 people living with AIDS in 2001."
- Indicator or progress, which is a statement that defines what would be considered success for the measure. For example, for the measure listed above, the indicator of progress is a decreased death rate.
- The data source for the measure and any other reference information necessary to better understand the measure. For example, for the measure listed above, the data source is the New York City Department of Health.

In some instances, quantifiable data are not available to measure the success of an objective; in such cases "process measures" are used instead. Process measures ask the question, "Did the Work Group complete the tasks they set for themselves?"

Where process measures are used to indicate plan success, the action steps listed in Chapter 2 are repeated in the monitoring plan. Because success is measured by action step completion, baselines are not listed. As each Work Group is the source of information regarding action step completion, "source" information is also not included. Note that success measures for the Policy and Data Committees, because of the nature of their mandates, are all process-oriented.

The following terms related to the CHAIN study are mentioned in the framework:

- MOS SF-36 refers to the proprietary Medical Outcomes Study Short Form 36-item scale, which is used to produce CHAIN's physical component summary score (PCS) and the mental component summary score (MCS). These scales were originally developed by John Ware and colleagues in the 1980s and have undergone considerable reliability and validity testing.
- Under the column headed "Data Source/Reference Information," the term "wave" refers to the yearly round of interviews in which all eligible respondents in the cohort are interviewed. Answers from waves 5 through 8 (from 1997-2002) are combined to allow for the most recently available data. In other words, CHAIN preferentially takes individual client data from the eighth round of interviewing. If that is not available, they take information for that individual from the most recent wave in which he/she participated, going back as far as wave 5, if necessary.

**AOD  
Work Group  
in New  
York City**

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**Goal 1: Improve the health of AOD users.**

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**Objective 1A: Health care, mental health and other providers will provide culturally and linguistically appropriate and sensitive services to AOD users.**

*Measure:*

Among CHAIN participants who reported current or past drug use, questions measuring barriers to care: "...Did you ever delay or not get assistance you thought you needed because staff ...are often not polite, disrespectful, or insensitive to your needs, not sure they ...would understand your problems, or ...not good at listening to your problems or needs?"

*Baseline:*

16% of respondents with past or current drug use reported that they experienced cultural barriers to social and/or medical care.

*Indicator of Progress:*

Decreased % reporting cultural barriers.

*Data Source/Reference Information:*

CHAIN; latest observation point between wave 5 - wave 8, 1997 - 2002 (n=534).

---

**Objective 1B: Health care, mental health, and other services will be more accessible to AOD users.**

*Measure:*

Among CHAIN participants who reported current or past drug use and had objective need for mental health services (scored <37.0 on the Mental Health Component Summary score of the SF-36, developed by the MOS), those who reported that they received professional (psychiatrist or psychologist) or supportive (e.g. counseling from case manager, clergy, etc.) mental health services.

*Baseline:*

48% of respondents with past or current drug use and with need for mental health services reported receiving mental health services.

*Indicator of Progress:*

Increased % reporting receipt of mental health services.

*Data Source/Reference Information:*

CHAIN; latest observation point between wave 5 - wave 8, 1997 - 2002 (n=534).

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**Goal 2: Improve the housing stability of AOD users.**

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**Objective 2A: Safe, stable, low threshold housing will be available to AOD users.**

*Measure:*

CHAIN participants who reported current drug use and also reported being unstably housed: any episode of living in street, shelter, single room occupancy, or doubled up with a friend or relative.

*Baseline:*

34% of respondents who reported current drug use reported being unstably housed.

*Indicator of Progress:*

Decreased % who report being unstably housed.

*Data Source/Reference Information:*

CHAIN; latest observation point between wave 5 – wave 8, 1997 – 2002 (n=161).

---

**Objective 2B: AOD users will have access to a broad continuum of services that are comprehensively integrated into the range of housing settings.**

*Process Measure: Was the following action step completed?*

Collaborate with the Housing Work Group to incorporate focus group findings (see action steps for AOD objective 1A) into AOD and/or housing templates.

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**AOD  
Work Group  
in New  
York City**

**AOD  
Work Group  
in New  
York City**

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**Goal 3: Reduce AOD-related harm.**

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**Objective 3A: Ensure that AOD users have access to a high quality continuum of services, including low threshold/harm reduction services, upon demand.**

*Process Measures: Were the following action steps completed?*

Advocate to the legislature for overdose legislation, approval of buprenorphin treatment as an alternative to methadone, and study of the option to allow psychologists to dispense medication.

Investigate the availability of AOD services in zip codes found to have high rates of HIV co-morbidity. Target AOD services accordingly, making sure that the full range of desired services are available (including harm-reduction services).

Allocate resources to assist the transition of prison releasees back into the community, e.g. escort/follow-up workers.

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**Goal 4: Ensure the effective communication, coordination, and collaboration among consumers and service providers.**

---

**Objective 4A: Provider-to-provider and provider-to-client communications will be appropriate, effective, and confidential.**

*Process Measure: Was the following action step completed?*

Advocate for the clarification of drug and HIV-related confidentiality procedures such that regulations promote effective communication while maintaining the right to privacy.

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**Goal 1: Ensure that people with HIV achieve and maintain optimal health and well being.**

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**Health Services  
Work Group  
in New  
York City**

**Objective 1A: Persons with HIV disease engaged in health care services will have improved survival and health outcomes.**

*Measure:*

CHAIN participants self-reported health status, as measured by the Physical Component Summary (PCS) score of the SF-36, developed by the MOS.

*Baseline:*

49% of CHAIN respondents reported a high PCS score (PCS $\geq$ 45.0).

*Indicator of Progress:*

Increased % who report a high PCS score.

*Data Source/Reference Information:*

CHAIN; latest observation point between wave 5 – wave 8, 1997 – 2002 (n=648).

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*Measure:*

CHAIN participants self-reported T-cell count.

*Baseline:*

24% of respondents reported a T-cell count of <200, 43% between 201-500, and 34% >500.

*Indicator of Progress:*

Increased % who report improved T-cell counts.

*Data Source/Reference Information:*

CHAIN; latest observation point between wave 5 – wave 8, 1997 – 2002 (n=652).

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*Measure:*

New York City HIV/AIDS mortality rate.

*Baseline:*

22:1,000 people living with AIDS.

*Indicator of Progress:*

Decreased death rate.

*Data Source/Reference Information:*

New York City Department of Health; data from calendar year 2001.

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**Health Services  
Work Group  
in New  
York City**

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**Objective 1B: Persons with HIV disease who receive health services will adhere to treatments.**

*Measure:*

CHAIN participants' self-reported adherence to HIV antiretroviral medication plus no reported missed pills in prior two days to interview.

*Baseline:*

66% of respondents reported being adherent to HIV antiretroviral medication.

*Indicator of Progress:*

Increased % who report adherence.

*Data Source/Reference Information:*

CHAIN; latest observation point between wave 5 – wave 8, 1997 – 2002 (n=430).

---

**Goal 2: Provide access to care for people with HIV disease throughout the EMA.**

---

**Objective 2A: Persons with HIV disease engaged in care will remain connected to services once they have entered the continuum of care.**

*Measure:*

CHAIN participants self-report primary medical care doctor from same agency as last interview (approximately one year ago).

*Baseline:*

72% of respondents reported continuing care from the same primary care physician.

*Indicator of Progress:*

Increased % who report continuous care from the same physician.

*Data Source/Reference Information:*

CHAIN; latest observation point between wave 5 - wave 8, 1997 - 2002 (n=506).

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**Objective 2B: Persons with HIV who are unconnected to care will access the continuum of care.**

*Measure:*

Percent of newly diagnosed HIV cases in New York City that are simultaneously diagnosed with AIDS.

*Baseline:*

33%

*Indicator of Progress:*

Decreased % who are simultaneously diagnosed.

*Data Source/Reference Information:*

New York City Department of Health; most recent data from June 1, 2000–December 31, 2001.

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**Objective 2C: Services across the continuum of care from outreach through long-term care will be linked and integrated.**

*Process Measures: Were the following action steps completed?*

Gather and analyze data on service linkage and integration.

Identify policies and methods to enhance service linkage and integration.

Allocate resources to support service linkage and integration.

**Comment:** Consider an initiative to explore the use of the URS system to report referral data.

---

**Health Services  
Work Group  
in New  
York City**

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**Goal 3: Ensure that HIV care and services are high quality.**

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**Objective 3A: Persons with HIV disease in care receive services that meet or exceed the quality standards of the New York State AIDS Institute.**

*Measure:*

CHAIN participants who met three AIDS Institute criteria for appropriate medical care: required number of medical care visits (further contingent upon T-cell count and antiretroviral use), self-reported complete physical and blood work, and self-reported T-cell count.

*Baseline:*

73% of respondents met AIDS Institute standards of care for appropriate medical care.

*Indicator of Progress:*

Increased % who meet AIDS Institute standards of care.

*Data Source/Reference Information:*

CHAIN; latest observation point between wave 5 - wave 8, 1997 - 2002 (n=652).

---

**Objective 3B: Persons with HIV disease in care report their health-related quality of life as "good" or better.**

*Measure:*

Single global question of CHAIN participants measuring self-reported health status: "In general, would you say your health is excellent, very good, good, fair, or poor?"

*Baseline:*

34% of respondents reported that their health in general was either "excellent, very good, or good."

*Indicator of Progress:*

Increased % who report good health.

*Data Source/Reference Information:*

CHAIN; latest observation point between wave 5 - wave 8, 1997 - 2002 (n=648).

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**Goal 4: Respond to changes in publicly financed HIV care and services.**

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**Objective 4A: The Planning Council will receive timely information on the impact of major external changes affecting the continuum of care.**

*Process Measures: Were the following action steps completed?*

Gather and analyze data on major external changes affecting the continuum of care.

Allocate resources as necessary to respond to new needs resulting from changes in the external environment.

---

**Objective 4B: The Planning Council will take action to address new demands on the continuum of care, such as full implementation of Special Needs Plans (SNPs).**

*Process Measures: Were the following action steps completed?*

Gather and analyze data on the full implementation of SNPs.

Allocate resources as necessary to respond to new needs resulting from full implementation of SNPs.

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*Health Services  
Work Group  
in New  
York City*

**Housing  
Work Group  
in New  
York City**

---

**Goal 1: Increase the volume of housing units that are appropriate for people with HIV/AIDS.**

---

**Objective 1A: Transitional housing will be available to people with HIV/AIDS who need it.**

*Measure:*

CHAIN participants who reported being unstably housed: any episode of living in street, shelter, commercial single room occupancy, or doubled up with a friend or relative.

*Baseline:*

18% of respondents reported being unstably housed.

*Indicator of Progress:*

Decreased % who report being unstably housed.

*Data Source/Reference Information:*

CHAIN; latest observation point between wave 5 - wave 8, 1997 - 2002 (n=652).

---

**Goal 2: Expedite access to existing housing and provide supportive services for people with HIV/AIDS.**

---

**Objective 2A: Housing placement assistance services will be available for persons with HIV disease who need it.**

*Measure:*

Among CHAIN participants who reported being unstably housed (see above), 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:*

32% of respondents who need housing services reported receiving such services.

*Indicator of Progress:*

Increased % of those who need housing services report receiving such services.

*Data Source/Reference Information:*

CHAIN; latest observation point between wave 5 - wave 8, 1997 - 2002 (n=118).

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**Objective 2B: Persons with HIV disease who need housing-related supportive services will have them.**

*Measure:*

Number of special population encounters through Title I supported housing.

*Baseline:*

Number of encounters:

- AOD group counseling (1,587)
- Mental health group counseling (1,819)
- AOD individual counseling (11,481)
- Mental health individual counseling (20,456)

*Indicator of Progress:*

Increased number of encounters in each category.

*Data Source/Reference Information:*

MHRA; latest observation point between March 2000 and February 2001.

---

**Objective 2C: Emergency rental assistance will be available to people with HIV/AIDS who need it.**

*Measure:*

Number of months during which Title I's Sustainable Living Fund (which provides emergency rental assistance) did not accept clients.

*Baseline:*

No baseline available at this time.

*Indicator of Progress:*

Decreased number of months during which the Sustainable Living Fund did not accept clients.

*Data Source/Reference Information:*

MHRA.

---

***Housing  
Work Group  
in New  
York City***

---

**Goal 3: Improve the quality of housing in which people with HIV/AIDS are living.**

---

**Objective 3A: Housing and/or housing-related services for persons with HIV/AIDS will be appropriate and of high quality.**

*Measure:*

Number of providers receiving Title I funded technical assistance for housing.

*Baseline:*

Number of encounters:

- Workshops/training (35)
- Technical assistance contacts (3,219)

*Indicator of Progress:*

Increased number of encounters in each category.

*Data Source/Reference Information:*

MHRA; latest observation point between March 2000 and February 2001.

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---

**Goal 1: Empower people with HIV to make informed personal health choices and assist providers in delivering quality HIV services.**

---

**Objective 1A: Appropriate information will be available on type and location of services and on options for choosing services that best meet the needs of persons with HIV.**

*Measure:*

CHAIN participants answers to questions measuring barriers to care: "...Did you ever delay or not get assistance you thought you needed because ...you didn't know or weren't sure where to go for medical or social services?"

*Baseline:*

9% of respondents reported that they experienced barriers to social and/or medical care because they did not know or were unsure of where to go for care.

*Indicator of Progress:*

Decreased % reporting barriers due to lack of knowledge as to where to go for care.

*Data Source/Reference Information:*

CHAIN; latest observation point between wave 5 - wave 8, 1997 - 2002 (n=652).

---

**Objective 1B: Persons with HIV disease will provide meaningful input to HIV/AIDS service organizations on program design, implementation, and evaluation.**

*Process Measures: Were the following action steps completed?*

Identify models for Consumer Advisory Boards (CABs).

Set guidelines and standards for CABs.

Promote marketing and education on CABs.

Evaluate the effectiveness of CABs.

Allocate resources for CAB-related training and technical assistance.

**Comment:** MHRA is in the process of developing a methodology to measure the effectiveness of Consumer Advisory Boards.

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**Infrastructure  
Work Group  
in New  
York City**

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**Goal 2: Strengthen the continuum of care for persons with HIV by building the capacity of service providers.**

---

**Objective 2A: Providers will access and use appropriate outcome-based technical assistance to improve the quality and reach of their services.**

*Process Measures: Were the following action steps completed?*

Gather and analyze data on the need for and effectiveness of technical assistance.

Identify models of technical assistance that are outcome based.

Promote marketing of technical assistance.

Allocate resources to support technical assistance.

---

**Objective 2B: Providers will deliver services that reflect the meaningful input of consumers they serve.**

*Process Measures: Were the following action steps completed?*

Gather and analyze data from consumers on their experiences with providing input.

**Comment:** MHRA is in the process of developing a methodology to measure the effectiveness of Consumer Advisory Boards.

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**Goal 1: Ensure a continuum of appropriate, high quality mental health care and services.**

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**Mental Health  
Work Group  
in New  
York City**

**Objective 1A: Persons with HIV disease will receive mental health care and services that meet clinical and practice standards, achieving parity with other health care services.**

*Process Measures: Were the following action steps completed?*

Collaborate on the development and dissemination of performance standards for the provision of high quality mental health services for people with HIV.

Provide guidance to the grantee to assure that professional mental health services are provided by NYS licensed providers with appropriate experience, training, and ongoing supervision.

Collaborate on the development of HIV-specific training, biannually at a minimum, for mental health professionals to address issues such as case finding, drug interactions, transitional planning, HIV treatment updates, and adherence.

Provide guidance to the grantee that leads to mechanisms ensuring that standards of care and service guidelines are met.

Recommend continuation of studies on existing and emerging issues to ensure proper planning regarding their impact on mental health care.

---

**Objective 1B: Persons with HIV disease engaged in mental health care and services will adhere to treatment.**

*Measure:*

Among CHAIN participants who had objective need for and received mental health services (scored <37.0 on the Mental Health Component Summary score of the SF-36, developed by the MOS), those who self-reported being adherent to HIV medication plus no reported missed pills in prior two days to interview.

*Baseline:*

61% of respondents who had need for mental health services reported being adherent to HIV treatment.

*Indicator of Progress:*

Increased % report being adherent to HIV treatment.

*Data Source/Reference Information:*

CHAIN; latest observation point between wave 5 - wave 8, 1997 - 2002 (n=107).

---

**Mental Health  
Work Group  
in New  
York City**

**Objective 1C: Persons with HIV disease engaged in mental health care and services will have improved quality of life.**

*Measure:*

Among CHAIN participants who had objective need for and received mental health services (scored <37.0 on the Mental Health Component Summary score of the SF-36, developed by the MOS), their self-reported health status, as measured by the Physical Component Summary score of the SF-36, developed by the MOS.

*Baseline:*

29% of respondents who had need for mental health services reported having high (PCS>=45.0) health status.

*Indicator of Progress:*

Increased % report having high health status.

*Data Source/Reference Information:*

CHAIN; latest observation point between wave 5 - wave 8, 1997 - 2002 (n=175).

**Goal 2: Facilitate access, engagement, and retention in care by providing integrated mental health care and services.**

**Objective 2A: Persons with HIV disease will receive appropriate assessments for mental health needs.**

*Process Measures: Were the following action steps completed?*

Identify mental health assessment protocol that can be used across all disciplines within the HIV services arena to assure proper referrals. Provide guidance to the grantee requiring use of the protocol in contract service provisions.

Provide guidance to the grantee requiring all people with HIV disease in care receive a global assessment of bio/psycho/social/spiritual needs in all service settings at program entry, quarterly, and as clinically indicated.

Recommend continuation of study of existing and emerging special populations to ensure engagement into care and proper planning efforts with regard to mental health services.

Allocate resources to address service gaps and needs of special populations.

**Objective 2B: Persons with HIV disease will receive mental health services that are linked and integrated with health care and other supportive services to promote retention in care.**

*Process Measures: Were the following action steps completed?*

Collaborate on the development of training and technical assistance to help providers create comprehensive service programs that network and link primary care, social services, housing, AOD and mental health.

Allocate resources in support of service models in primary care/health, social service, AOD and housing settings that co-locate and/or link to professional mental health services.

---

***Mental Health  
Work Group  
in New  
York City***

**Social Services  
Work Group  
in New  
York City**

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**Goal 1: Provide a comprehensive range of available and accessible HIV-related social service programs.**

---

**Objective 1A: People living with HIV disease will have local access to case management services.**

*Process Measure: Were the following action steps completed?*

Continue CHAIN mapping and service gaps research. Use these data to identify under-served geographic regions and special populations. Target services to high-need areas as appropriate.

---

**Objective 1B: People living with HIV disease will have access to culturally competent and linguistically appropriate social services.**

*Measure:*

CHAIN participants' answers to questions measuring barriers to care: "...Did you ever delay or not get assistance you thought you needed because the staff members ...do not speak your language, ...are not competent to deal with your problem, ...are often not polite, disrespectful, or insensitive to your needs, not sure they ...would understand your problems, or ...not good at listening to your problems or needs?"

*Baseline:*

15% of respondents reported that they encountered barriers to social services because staff did not speak their language or they experienced cultural barriers.

*Indicator of Progress:*

Decreased % reporting cultural barriers.

*Data Source/Reference Information:*

CHAIN; latest observation point between wave 5 - wave 8, 1997 - 2002 (n=548).

---

**Objective 1C: People living with HIV disease will have access to necessary transportation services.**

*Measure:*

Among CHAIN participants who reported needing help with transportation services or identified instances when lack of transportation was a barrier to receiving care in 6 months prior to interview, those who received transportation services.

*Baseline:*

43% of respondents who needed help with transportation got help.

*Indicator of Progress:*

Increased % reporting receiving needed transportation services.

*Data Source/Reference Information:*

CHAIN; latest observation point between wave 5 - wave 8, 1997 - 2002 (n=37).

---

**Objective 1D: People living with HIV disease will have access to a broad range of support, advocacy, and basic needs programs within their geographic area.**

*Measure:*

Among CHAIN participants who expressed needing assistance with legal matters, child care, or food, groceries, or 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:*

41-50% of respondents had unmet need for basic social services, specifically, legal matters, childcare, or food, groceries, and meals.

*Indicator of Progress:*

Decreased % reporting unmet needs.

*Data Source/Reference Information:*

CHAIN; latest observation point between wave 5 - wave 8, 1997 - 2002  
(legal: n=44)  
(child: n=6)  
(food: n=52)

---

**Goal 2: Ensure effective communication, coordination, and collaboration among social services, medical, housing, and other service providers.**

---

**Objective 2A: Linkages will be improved among social service, medical, mental health, substance abuse, food and nutrition, case management, housing, and legal service agencies.**

*Process Measure: Was the following action step completed?*

Provide guidance to the grantee requiring that MHRA regularly monitor and report on case management and ambulatory care referral arrangements.

---

**Objective 2B: Ensure effective dissemination of information about available services and program updates in each borough.**

*Process Measures: Were the following action steps completed?*

Recommend collaboration with the AIDS Institute regarding (1) the usefulness of Title II networks as currently configured, and (2) alternatives/improved approaches to achieving the tasks and outcomes currently assigned to the networks.

Recommend development of an Internet-based resource database for Title I service providers.

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**Social Services  
Work Group  
in New  
York City**

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**Goal 3: Ensure that people living with HIV disease have access to the knowledge, skills, and assistance necessary for them to successfully navigate and utilize services within a changing service delivery system.**

---

**Objective 3A: People living with HIV disease will have adequate knowledge regarding managed care and Special Needs Plans (SNPs).**

*Process Measures: Were the following action steps completed?*

Provide guidance to the grantee to assure social services provider training on changes in managed care and SNPs in contract service provisions.

Collaborate on the development and distribution of consumer education materials on managed care and SNPs.

---

**Objective 3B: People living with HIV disease will have adequate knowledge regarding treatment issues and adherence strategies.**

*Process Measures: Were the following action steps completed?*

Recommend pilot testing of treatment education and adherence models in non-medical settings.

Provide guidance to the grantee to assure social services provider training on treatment issues and adherence strategies in contract service provisions.

---

**Objective 3C: HIV/AIDS service providers will respond to welfare reform with a focus on ensuring that the basic needs of people living with HIV disease are met.**

*Process Measures: Were the following action steps completed?*

Recommend assessment of the impact of welfare reform on persons living with HIV disease.

Address policy barriers that prevent providers from responding effectively to the loss of government safety net programs.

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**Goal 4: To ensure the delivery of high quality social services.**


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**Objective 4A: People living with HIV disease who are eligible will receive the maximum benefits to which they are entitled.**

*Process Measure: Were the following action steps completed?*

Provide guidance to the grantee to assure social services provider training on the full range of entitlement programs and eligibility requirements in contract service provisions.

Recommend that the Planning Council establish a routine communication mechanism between HASA and AIDS service providers, including direct participation of HASA on the Social Services Work Group.

*Indicator of Progress:*

Maintain or increase those on Medicaid.

*Data Source/Reference Information:*

CHAIN; latest observation point between wave 5 - wave 8, 1997 - 2002 (n=124).

---

**Objective 4B: HIV/AIDS service providers will adhere to standards of care.**

*Process Measures: Were the following action steps completed?*

Participate in the development and adoption of performance standards being developed by the Title I Quality Management Program in coordination with the AIDS Institute.

Adopt existing AIDS Institute case management services standards of care and monitor adherence.

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**Social Services  
Work Group  
in New  
York City**

**Tri-County  
Region**

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**Goal 1: Maintain and enhance access to, and ensure a comprehensive continuum of care for, all Tri-County residents living with HIV/AIDS, especially disproportionately affected populations.**

---

**Objective 1A: Clients and providers will know what to do to access the services they need.**

*Measure:*

Tri-County CHAIN participants' answers to questions measuring barriers to care: "...Did you ever delay or not get assistance you thought you needed because ...you didn't know or weren't sure where to go for medical or social services?"

*Baseline:*

No baseline data available at this time.

*Indicator of Progress:*

Decreased % (once baseline is established) reporting barriers due to lack of knowledge as to where to go for care.

*Data Source/Reference Information:*

CHAIN.

---

**Objective 1B: Clients will receive the standard of care that meets or exceeds the New York AIDS Institute standards.**

*Measure:*

Tri-County CHAIN participants who met three AIDS Institute criteria for appropriate medical care: required number of medical care visits (further contingent upon T-cell count and antiretroviral use), self-reported complete physical and blood work, and self-reported T-cell count.

*Baseline:*

No baseline data available at this time.

*Indicator of Progress:*

Increased % (once baseline established) who meet AIDS Institute requirements.

*Data Source/Reference Information:*

CHAIN.

---

**Objective 1C: Clients will be linked to appropriate services through improved communication, coordination and referral among HIV/AIDS service providers and related agencies.**

*Process Measures: Were the following action steps completed?*

Develop and implement improved communication process/systems among providers, including interagency/multidisciplinary meetings.

Encourage linkages between HIV/AIDS service providers and related agencies.

Recommend agencies have access to the Internet to determine best services for clients.

Organize provider presentations at Title II Network meetings.

Create a Tri-County-specific comprehensive client needs assessment tool and train staff in its use.

Revise Tri-County HIV Resource Guide and include a section entitled, "What to do now that you've tested HIV+." Make guide available in both text and electronic format.

**Objective 1D: Persons with HIV/AIDS will receive appropriate housing and related services in the Tri-County region.**

*Measure:*

Among Tri-County CHAIN participants who reported being unstably housed (see above), 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:*

No baseline data available at this time.

*Indicator of Progress:*

Decreased % (once baseline established) reporting being unstably housed.

*Data Source/Reference Information:*

CHAIN.

**Tri-County  
Region**

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**Objective 1E: Assure a comprehensive continuum of care for HIV/AIDS services needed by people with HIV/AIDS in the Tri-County region.**

*Process Measures: Were the following action steps completed?*

Conduct a needs assessment to identify gaps and unmet needs of people living with HIV/AIDS.

Identify service models and plan programs.

Allocate resources to implement model programs.

Reassess and modify programs as needs and environment change.

---

**Goal 2: Bring those individuals who know their HIV-positive status, but are not yet in care, into the medical and supportive services system.**

---

**Objective 2A: The Tri-County Steering Committee will understand the extent to which people who know their status are not engaged in care, and the reasons they are not in care.**

*Measure:*

Percent of newly diagnosed HIV cases in Tri-County that are simultaneously diagnosed with AIDS.

*Baseline:*

No baseline data available at this time.

*Indicator of Progress:*

Decreased % who are simultaneously diagnosed.

*Data Source/Reference Information:*

New York State Department of Health; no baseline data available at this time.

---

**Objective 2B: People who know their status will be educated and informed about appropriate service options.**

*Process Measures: Were the following action steps completed?*

Allocate resources to fund agencies to deliver educational sessions on HIV care and treatment to consumers and providers.

Conduct consumer-focused needs assessment to determine education and service needs of consumers.

---

**Objective 2C: People who know their status and are not in care will be engaged through linked and coordinated services across the continuum of care.**

*Process Measures: Were the following action steps completed?*

Develop outreach programs to engage at-risk populations.

Develop outreach programs that reconnect people who were in care but are not currently engaged.

Develop a provider network that establishes linkages among providers.

---

**Goal 3: Engage individuals who are unaware of their HIV-positive status and bring them into the medical and supportive services system.**

---

**Objective 3A: Persons with HIV disease who do not know their HIV-positive status will choose to know their status and seek care.**

*Measure:*

Percent of newly diagnosed HIV cases in Tri-County that are simultaneously diagnosed with AIDS.

*Baseline:*

No baseline data available at this time.

*Indicator of Progress:*

Decreased % who are simultaneously diagnosed.

*Data Source/Reference Information:*

New York State Department of Health; no baseline data available at this time.

---

**Objective 3B: At-risk populations and their service providers will be educated about how to bring persons with HIV who do not know their status into testing and medical care.**

*Process Measures: Were the following action steps completed?*

Develop outreach programs for caregivers and families.

Develop a mobile outreach and testing program that operates outside of the regular workday and visits locations in the region that are known to be places where hard-to-reach populations are found.

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**Data  
Measures**

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**Goal 1: Provide data, for the purposes of planning, on the needs of persons with HIV, trends in the external environment that affect them, and other relevant information.**

---

**Objective 1A: A comprehensive and accessible resource of recent local, State, and Federal planning data will be available.**

*Process Measures: Were the following action steps completed?*

Develop and maintain a resource library of local, State, and Federal planning data.

---

**Objective 1B: The resource library will be used by the EMA for annual updates to the strategic plan, and for annual resource allocation, implementation, and evaluation.**

*Process Measures: Were the following action steps completed?*

Use the resource library for the annual update of this plan.

Use the resource library for the annual priority setting and resource allocation process.

Use the resource library for setting priorities for new evaluation initiatives.

---

**Objective 1C: The strategic plan's goals and objectives will be measured and reported to the appropriate parties at least once a year.**

*Process Measures: Were the following action steps completed?*

Gather and analyze data necessary to measure the plan's goals and objectives.

Develop a work plan of activities to assure that measuring the plan is ongoing and timely.

Develop and report annually updates of the plan.

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**Goal 2: Enhance knowledge of the distribution and utilization of health and human services for persons with HIV and promote better understanding of the impact of those services.**

---

**Objective 2A: Distribution and utilization data for Title I services will be timely, descriptive, complete, and accurate.**

*Process Measures: Were the following action steps completed?*

Develop data requests and initiatives that respond to priority planning questions and tasks.

Disseminate new data reports on distribution and utilization data.

---

**Objective 2B: Client-level data for planning and program development will be available from an EMA-wide comprehensive information management system.**

*Process Measures: Were the following action steps completed?*

Develop a mechanism to report unduplicated client-level data incorporating Title I and Title II.

---

**Goal 3: Identify and address gaps in knowledge regarding the health and human service needs of persons with HIV.**

---

**Objective 3A: Gaps in knowledge regarding the needs of communities, specific populations, and emerging trends affecting persons with HIV will be identified and prioritized.**

*Process Measures: Were the following action steps completed?*

Develop data requests to fill gaps in knowledge regarding needs of geographic communities, specific populations, and emerging trends.

---

**Data  
Measures**

**Objective 3B: Ongoing and special studies related to gaps in knowledge will be developed and their results integrated into planning and priority setting.**

*Process Measures: Were the following action steps completed?*

Develop ongoing and special studies to address gaps in knowledge.

Disseminate findings from these studies to the appropriate planning groups and processes.

**Policy  
Measures**

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**Goal 1: Develop Planning Council policies that contribute to the health and quality of life of persons with HIV in the New York EMA.**

---

**Objective 1A: Key policy issues will be monitored, analyzed, and reported to the Planning Council and others as appropriate.**

*Process Measures: Were the following action steps completed?*

Develop mechanisms to monitor, analyze, and report on key policy issues.

Develop a work plan for establishing policy positions and action steps related to Federal CARE Act annual appropriations and 2005 reauthorization.

Provide input to draft reports and presentations prepared for the Planning Council and its Work Groups.

---

**Objective 1B: Policy positions will be developed with input from the community and from outside experts where needed.**

*Process Measures: Were the following action steps completed?*

Coordinate policy development with other key policy, planning, and advisory boards.

Implement mechanisms (such as public forums) seeking input from the community.

Obtain input from outside experts on policy issues where appropriate.

---

**Objective 1C: Policy positions that are adopted will be acted upon through coordinated community-based and national advocacy.**

*Process Measures: Were the following action steps completed?*

Implement action steps related to policy positions.

Evaluate effectiveness of action steps that are implemented.

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**Goal 2: Ensure community input and collaboration on Title I policy and planning.**

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*Policy  
Measures*

**Objective 2A: Community input to the Planning Council's policy and planning activities, including priority setting, will be meaningful, consistent, and timely.**

*Process Measures: Were the following action steps completed?*

Obtain community input on planning and priority setting.

Evaluate and report community input.

---

**Objective 2B: Policy and planning decisions will reflect coordination and collaboration within the Title I planning process and outside it where possible.**

*Process Measures: Were the following action steps completed?*

Coordinate and collaborate policy and planning decision-making with appropriate parties.

Evaluate coordination and collaboration of policy and planning decision-making.

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## Appendix A: Glossary

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**ADAP:** AIDS drug assistance program.

**AOD:** Alcohol and other drugs.

**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.

**Cohort:** A group of individuals participating in a research study over time who start the study at the same time and are periodically resurveyed or reexamined at the same time.

**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.

**HAART:** Highly active antiretroviral therapy.

**Harm reduction:** Services that seek to engage drug users at their current level of function, and provide them with the education and material means they need to use drugs more safely, and to encourage them in making small, incremental changes in the direction of less harm.

**IDU:** Injection drug user.

**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.

**PLWA:** People living with AIDS.

**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.

**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.

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

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

**Special needs:** Broad descriptions of a 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 a population.

## Appendix B: Sources Used for Planning

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This appendix lists the sources used for developing the *Initial Needs Assessment for New York City 2002*. The needs assessment provided the evidence used by the Planning Council to develop this plan.<sup>31</sup>

A separate needs assessment was developed for the Tri-County region. The list of sources used for developing the *Initial Needs Assessment for the Tri-County Region 2002* is presented immediately following the New York City source documents, below.

The Office of the Mayor/AIDS Policy Coordination, the New York City Department of Health & Mental Hygiene, and MHRA provided many of the documents. In addition, the Planning Council Work Groups, planning committees, as well as the PWA 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. Output from this database on key subjects, such as specific populations and service categories, was then used to develop the tables and narrative of this needs assessment.<sup>32</sup>

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 locate row 89 on this table to find out the full title of

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<sup>31</sup> Through March 1, 2002

<sup>32</sup> The database of abstracts is available for future planning questions.

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.

**Sources by Abstract Code Number for New York City Initial Needs Assessment**

<b>Code #</b>	<b>Title Date</b>	<b>Source/ Authors</b>
<b>A</b>	<b>B</b>	<b>C</b>
001	The Epidemiology of AIDS in New York City December 2001	New York City Department of Health (DOH), HIV/AIDS Surveillance
002	Surveillance Update Including Persons Living with AIDS in New York City Reported through December 2001 June 2002	DOH HIV/AIDS Surveillance
003	New York City Children Perintally Exposed to HIV, Semiannual Surveillance Update May 2001	DOH HIV/AIDS Surveillance
004	Surveillance Update, Including Persons Living with AIDS in New York City reported through December 2001 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 <a href="http://nyc.gov/html/doh/html/rw/rw4.html">http://nyc.gov/html/doh/html/rw/rw4.html</a>	DOH

*Sources by  
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<b>Code #</b>	<b>Title Date</b>	<b>Source/ Authors</b>
<b>A</b>	<b>B</b>	<b>C</b>
015	NYC Ryan White Title I Service Directory Program Services by Agency <a href="http://nyc.gov/html/doh/html/re/rwa.html">http://nyc.gov/html/doh/html/re/rwa.html</a>	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

<b>Code #</b>	<b>Title Date</b>	<b>Source/ Authors</b>
<b>A</b>	<b>B</b>	<b>C</b>
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 February 2000	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] Undated	Columbia
033	CHAIN Update Report #28: Women's Needs and Utilization of Services by Family Types June 2000	Columbia

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<b>Code #</b>	<b>Title Date</b>	<b>Source/ Authors</b>
<b>A</b>	<b>B</b>	<b>C</b>
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

<b>Code #</b>	<b>Title Date</b>	<b>Source/ Authors</b>
<b>A</b>	<b>B</b>	<b>C</b>
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

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<b>Code #</b>	<b>Title Date</b>	<b>Source/ Authors</b>
<b>A</b>	<b>B</b>	<b>C</b>
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	Work Group 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

<b>Code #</b>	<b>Title Date</b>	<b>Source/ Authors</b>
<b>A</b>	<b>B</b>	<b>C</b>
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

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<b>Code #</b>	<b>Title Date</b>	<b>Source/ Authors</b>
<b>A</b>	<b>B</b>	<b>C</b>
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

<b>Code #</b>	<b>Title Date</b>	<b>Source/ Authors</b>
<b>A</b>	<b>B</b>	<b>C</b>
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 Undated	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

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<b>A</b>	<b>B</b>	<b>C</b>
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

<b>Code #</b>	<b>Title Date</b>	<b>Source/ Authors</b>
<b>A</b>	<b>B</b>	<b>C</b>
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	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

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<b>Code #</b>	<b>Title Date</b>	<b>Source/ Authors</b>
<b>A</b>	<b>B</b>	<b>C</b>
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

**Sources by Abstract Code Number for Tri-County region  
Initial Needs Assessment**

<b>Code #</b>	<b>Title/Date/Source/Authors</b>
<b>A</b>	<b>B</b>
011	New York EMA FY2002 Ryan White CARE Act Title I Grant Application, September 2001, NYC Department of Health, N.Y., N.Y.
012	New York EMA FY2001 Ryan White CARE Act Title I Grant Application, September 2000, NYC Department of Health, N.Y., N.Y.
112	Preliminary Report: Regional Gap Analysis (Tri-County), Lower Hudson HIV CARE Network, March 2001, NYS Department of Health, N.Y., N.Y.
118	Community Needs Index (Hudson Valley Region), 2000.
T120	"Cumulative Number of Adult (13 Years and Older) AIDS Cases Including NYS Prison Inmates, by Age, Race, Sex and Risk," Table 4H, AIDS Surveillance Quarter Update, Data as of June 30, 2000, NYS DOH/BHAE.
T121	"Presumed Alive Adult (13 Years and Older) AIDS Cases Including NYS Prison Inmates by Age, Race, Sex and Risk," Table 6H, AIDS Surveillance Quarter Update, Data as of June 30, 2000, NYS DOH/BHAE.
T122	"Cumulative Number of AIDS Cases and Incidence Rates Per 100,000 Population in NYS by County of Residence at Diagnosis – Including NYS Prison Inmates," Table 3, AIDS Surveillance Quarter Update, Date as of June 30, 2000.
T123	Gable, Carol, "Glance at Cumulative AIDS Cases in the Tri-County Region, New York State and the United States, as of June 30, 2000," Presentation to the Westchester County Department of Health, February 26, 2002.
T124	DP-1. Profile of General Demographic Characteristics: 2000. Data Set: Census 2000 Summary File (SF 1) (Putnam, Rockland, Westchester Counties), 2000 Census, U.S. Census Bureau.

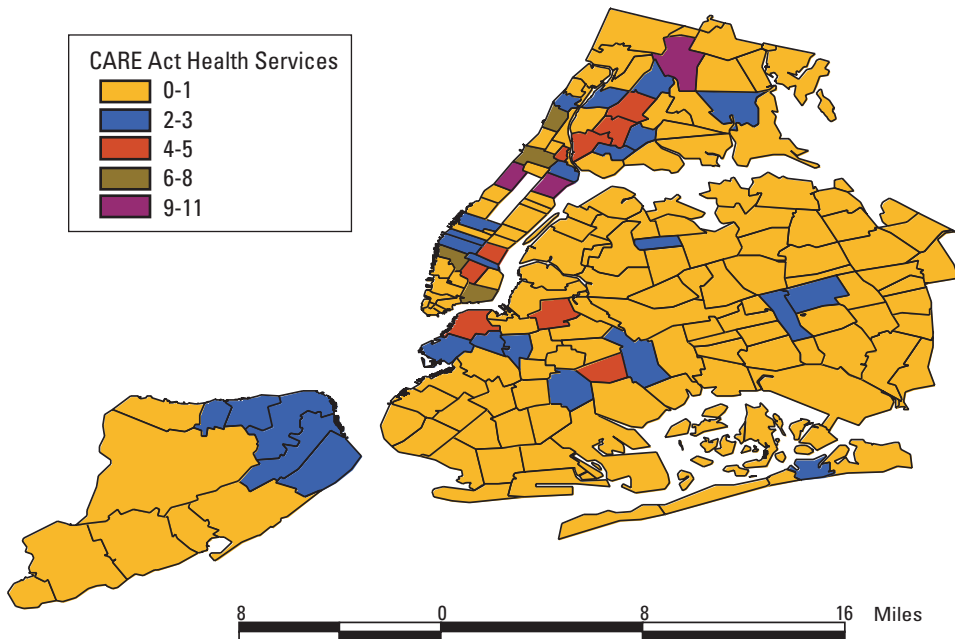
Sources by  
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Code #	Title/Date/Source/Authors
A	B
T125	“Confirmed AIDS Cases (Excluding Pediatric & Inmate Cases) Rockland County,” Data as of June 30, 2000, NYS DOH/BHAE; “Confirmed AIDS Cases (Excluding Pediatric & Inmate Cases) Putnam County,” Data as of June 30, 2000, NYS DOH/BHAE; “Confirmed AIDS Cases (Excluding Pediatric & Inmate Cases) Westchester County,” Data as of June 30, 2000, NYS DOH/BHAE.
T126	DP-1. General Population and Housing Characteristics: 1990 Data Set: 1990 Summary File 1 (STF 1) – 100-Percent Data. Geographic Area: Westchester, Rockland and Putnam Counties, New York
T127	DP-1. Profile of General Demographic Characteristics: 2000. Data Set: Census 2000 Summary File (SF 1) (Putnam, Rockland, Westchester Counties), 2000 Census, U.S. Census Bureau.
T128	“ADAP Active Participants in 2001, by County, by Zip Code, by Gender, by Race, by Age,” NYS DOH, AIDS Institute, HIV Uninsured Care Programs, April 2002.
T129	QT-P2. Single Years of Age Under 30 Years and Sex: 2000. Data Set: Census 2000 Summary File (SF-1) 100 Percent Data. (Putnam, Rockland and Westchester Counties). 2000 Census, U.S. Census Bureau.
T130	AIDS Cases Diagnosed Among Persons in the Lower/Mid-Hudson for Persons Presumed Alive Through June 30, 2000 (Including Inmates), by Selected Characteristics, NYS DOH/BHAE.
T131	Prevalence of Adult Alcoholism and Substance Abuse Treatment Need (Alcohol and non-narcotic drugs) 2002 County Resource Book, Vol. 1, Table 2, Page 2, NYSOASAS, April 2001.
T132	Selected Characteristics of Clients Admitted to ASA Treatment (1999) Primary Drug of Abuse (All Service Categories), 2002 County Resource Book, Vol. 1, Table 10, Page 36, NYSOASAS, (cds, extract 2/01)
T133	Population Estimates for Counties by Age, Race, Sex & Hispanic Origin, July 1, 1999. U.S. Census Bureau.
T134	“A Policy Transition Paper on Improving HIV/AIDS Services,” Federation of Protestant Welfare Agencies, 2002, New York, N.Y.

## Appendix C: CARE Act-Funded Service Sites

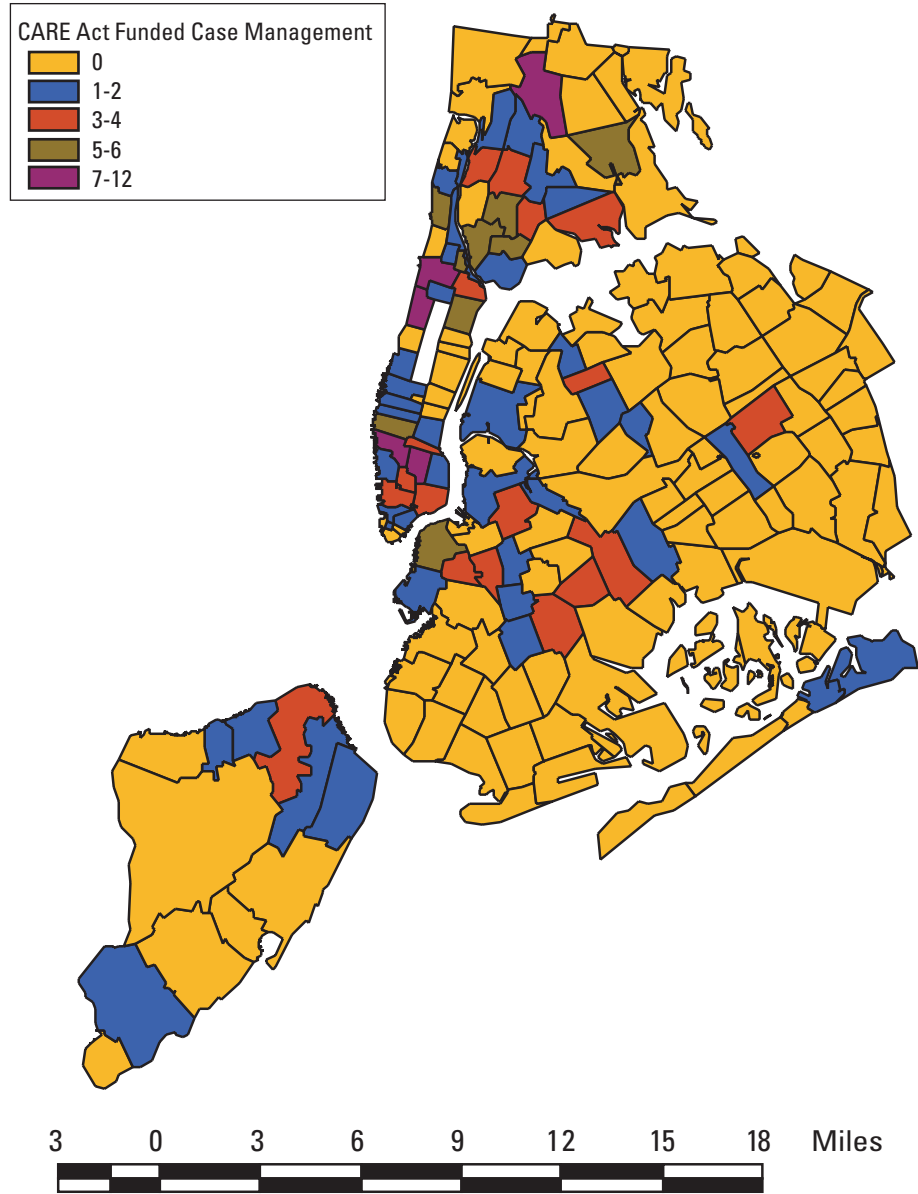
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### Health

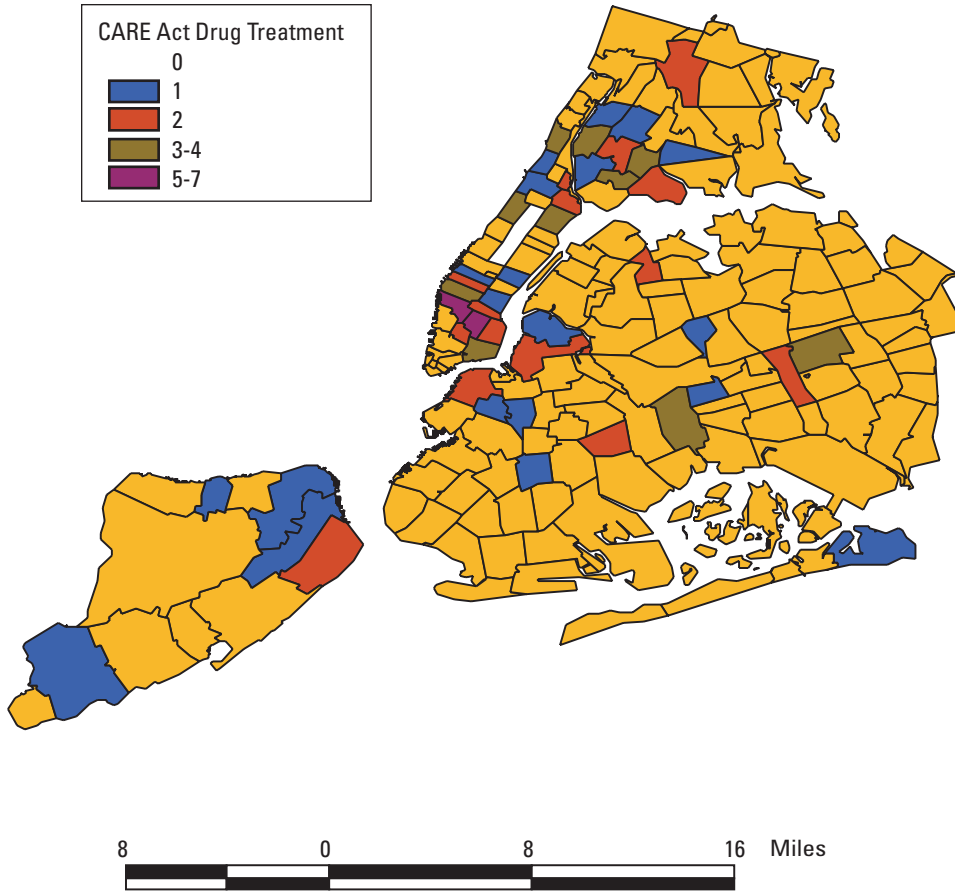


Source for all maps in this appendix: Document 019: CHAIN Update Report #42: A Geographic Display of the CHAIN Cohort's Service Utilization, December 2001, Columbia University and MHRA. Data reflect administrative contract data from CARE Act Title I (Year 10), Title II, Title II, Title IV, and Special Projects of National Significance.

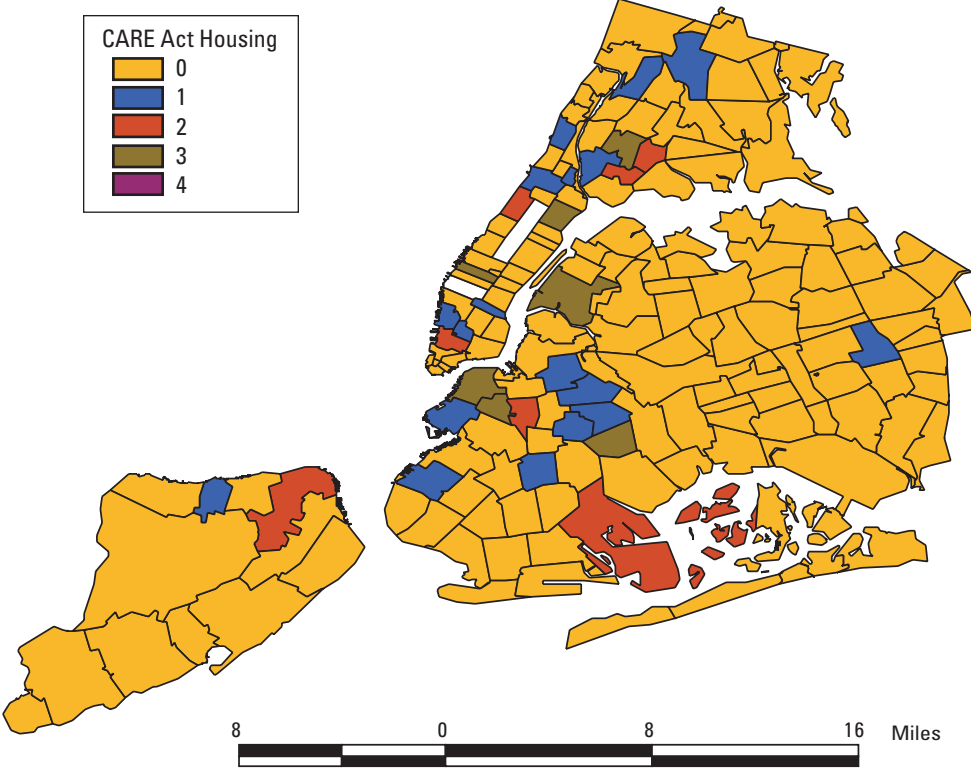
## Case Management Sites



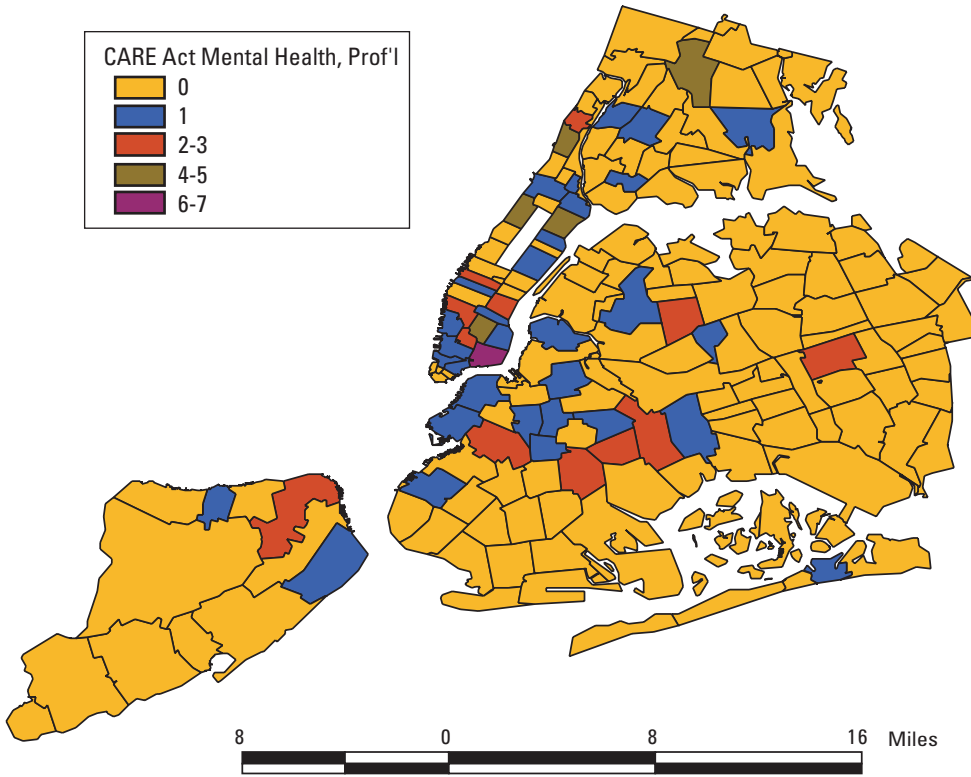
# Drug Treatment



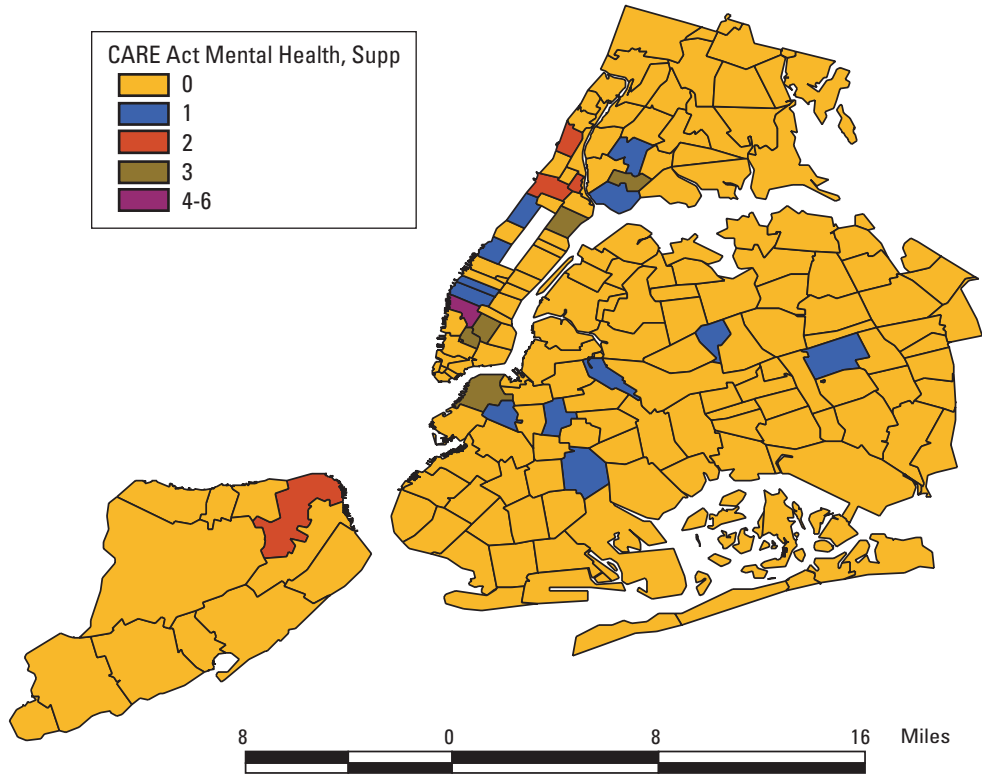
# Housing



## Professional Mental Health



## Supportive Mental Health



## Appendix D: Assessment of Service Gaps and Unmet Needs

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The follow table presents potential gaps in 25 different Title I-eligible services as identified by people with HIV disease (primarily available through the CHAIN project) column B, and by researchers, providers, and others, column C. 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 sources in Appendix B.

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. The information in the table is determined by the survey questions posed to people with HIV disease and by the topics pursued by researchers.

In total, the data in this table 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 the table 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 *Initial Needs Assessment for New York City 2002*, 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 antiretroviral 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 AOD users 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 with mental illness (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.

**Assessment of Service Gaps and Unmet Needs**

HRSA 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
<b>Ambulatory/outpatient medical care</b>	<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 (time between arriving for the appointment and seeing the provider) 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 Work Group 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>

**Assessment of Service Gaps and Unmet Needs**

HRSA 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 Work Group 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>

**Assessment of Service Gaps and Unmet Needs**

HRSA 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
<b>Medications</b>	<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>
<b>Health insurance</b>	<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>		
<b>Home health care</b>			<p>9:27. According to the DASIS quarterly performance report (Dec 2000), very few DASIS cases receive home care services.</p>

**Assessment of Service Gaps and Unmet Needs**

HRSA 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
<b>Oral health care</b>	<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>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 program, although an expected increase in Medicaid rates was postulated to improve this situation.</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>

**Assessment of Service Gaps and Unmet Needs**

HRSA Service Category	Service Gaps and Unmet Need		Special Population Issues
	Identified by People with HIV Disease	Identified by Researchers, Providers, and Others	
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<b>Oral health care</b> (continued)	<p>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>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>Specific dental utilization data were not available, according to the authors.</p> <p>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.</p>	
<b>Mental health services</b>	<p>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.</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>30:24 through 26. Per CHAIN (6/2000), persons with low mental health functioning are more likely to experience a loss of entitlement</p>	<p>73:4. According to a 7/2001 Y12 Mental Health Work Group 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.</p> <p>73-LS-3. Per a July 2001 Mental Health Work Group template (citing a May, 2001 CHAIN study), at least 40% of the original cohort has experienced clinically relevant mental health symptoms.</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. Very low mental health scores are highly correlated with substance use in PLWHA.</p>

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<b>Mental health services</b> (continued)	benefits between CHAIN interviews, perhaps due to missed appointments and/or failure to maintain proper income documentation.	76:1 through 3. Per a Social Services Work Group Y11 template, nutrition counseling needs to be integrated with the provision of food service.	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.
<b>Nutritional counseling</b>			
<b>Substance abuse services</b>	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 Work Group 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 treatment (methadone maintenance and abstinence-based programs) are not sufficiently available to meet the	

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Substance abuse services (continued)		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.		
		60:1 through 4. This Y11 AOD Work Group 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.		

**Assessment of Service Gaps and Unmet Needs**

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<b>Treatment adherence services</b>	<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>
<b>Child welfare services</b>	<p>33:3. Per CHAIN (6/2000), single mothers reported a lack of childcare 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 Work Group 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 &amp; 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>	

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<b>Case management</b>		9:2. According to the quarterly DASIS performance report for Oct-Dec 2000, most DASIS cases are in case management (72%), nearly 2/3 of clients are males, about half (49%) are African Americans. A large majority (83%) receive some form of housing assistance.	
<b>Client advocacy</b>		75:1 through 3. Per a Y11 Social Services Work Group 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.	
<b>Early intervention services</b>	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 Work Group 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. The Planning Council stated that outpatient medical care and case management service providers will be required to maintain formal, written referral relationships with	

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Early intervention services (continued)		<p>readiness" programs (based on harm reduction models). The provision of services that address basic survival needs may be necessary 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 Work Group 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</p>	<p>agencies at key points of entry into the health care system, for HIV testing and counseling center STD clinics. Other key points of entry, such as emergency rooms, homeless shelters, detoxification programs, adult/juvenile detention centers, federally qualified health care centers, and Ryan White Title I Access to Care programs, are encouraged to maintain these relationships.</p>

**Assessment of Service Gaps and Unmet Needs**

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<b>Early intervention services (continued)</b>		<p>have a direct link to counseling and testing services.</p> <p>60:1 through 4. Per a Y11 AOD Work Group 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>	
<b>Emergency financial assistance</b>		<p>67:10. According to a Housing Work Group Y12 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 &gt;75% of their income on rent.</p>	
<b>Food bank/home delivered meals/nutritional supplements</b>		<p>76:1 through 3. Per a Y11 Social Services Work Group template (7/2001), there is a need for additional food services for PLWHA. The Work Group prioritized funding the enhancement of existing congregate food programs and pantry programs.</p>	

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<b>Health education/ risk reduction</b>	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 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.  60:1 through 6. According to a 6/2000 AOD Work Group 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.	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.

**Assessment of Service Gaps and Unmet Needs**

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<b>Housing assistance</b>	<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 Work Group Y12 template (undated), the AOD population needs housing that is: low threshold, safe, and provides voluntary on-site services.</p> <p>65:1&amp;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>

**Assessment of Service Gaps and Unmet Needs**

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<b>Housing related services</b>	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.
<b>Legal services</b>		75:1 through 3. Per a Y11 Social Services Work Group 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.	

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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 &amp; 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 to engage this population.</p> <p>78:1 through 4. Per a Y12 Social Services Work Group 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>	

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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.	

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<b>Transportation</b>		<p>74:1. Per a Y11 Social Services Work Group 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 Work Group 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. The Rockaways in Queens (Winter 2001 Community Forum) and Staten Island (Staten Island HIV Care Network Service Delivery Plan 2001) particularly lack transportation.</p>
<b>Social Services in general</b>	<p>32:13. Per a CHAIN overview report (2000), consumers report greater unmet needs 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>

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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, and job re-entry assistance. Clients' 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, &gt;30% have low mental health functioning.</p>	<p>86:5. According to McClain &amp; 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 &amp; 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 addresses 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 &amp; 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>