

New York Eligible Metropolitan Area

ADDENDUM

TO THE

HIV/AIDS NEEDS ASSESSMENT UPDATE

2004

HIV Health & Human Services Planning Council of New York

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Section I. Introduction

In July 2004, the HIV Health and Human Services Planning Council of New York published an update to *the Initial Needs Assessment for New York City 2002*. The July 2004 *Needs Assessment Update* defined and described service needs and gaps in services for people living with HIV disease. The present document, entitled *Addendum to the Needs Assessment Update*, provides additional needs assessment information for the time period between May 1, 2004 and November 15, 2004.

This *Addendum* is *not* meant to be read in isolation. Rather, readers should use it in conjunction with the *Needs Assessment Update*. For questions that cannot be answered by either of these documents, readers should refer to the *2002 Needs Assessment and Comprehensive Plan for HIV/AIDS Services, 2002-2005*.

Throughout this document, readers will find sources referenced using the unique code number assigned to each source of data (see *Section 7* for a complete list of the data sources). In addition, where available, the specific page or slide number of that document is cited. This is intended to give the reader the ability to note specific objective evidence for future planning-related decision-making.

For example, “By the end of 2003, adults 50 years old or older constituted 18% of adults living with AIDS in NYC (224:2)” appears in *Section 3*. A reader interested in more information would first turn to *Section 7* and look up document #224, “*The Epidemiology of HIV/AIDS in Persons Age 50+*, Susan W. Forlenza MD MPH, New York City Department of Health and Mental Hygiene.” Page 2 of that document will contain the specific information cited in *Section 3*.

Together, the *Needs Assessment Update* and this *Addendum* will serve as the basis of evidence for the Planning Council’s planning activities leading to the EMA’s *Comprehensive Strategic Plan for HIV/AIDS Services, 2005-2008*.

Section II. Summary

The documents utilized for this *Addendum* do not alter the summary findings and recommendations presented in the *Needs Assessment Update* published in July 2004. It should be noted that this *Addendum* provides information on the New York City portion of the EMA.

Of the 9,627 children born to HIV-infected women in NYC as of the end of 2003, 3,766 were HIV-infected. The number of children diagnosed with HIV in NYC peaked in 1993. Declines in HIV diagnoses among children under 13 years of age are due to decreasing numbers of HIV-infected women delivering infants and the increasing use of prenatal antiretroviral therapies to prevent transmission (214:10). Transmission rates were lowest among deliveries where the mother received prenatal ZDV with other ART in addition to intrapartum and neonatal ZDV (214:14). The number of AIDS-defining conditions among children dropped dramatically after 1995, paralleling the drop in newly diagnosed children with AIDS (214:12).

A disproportionate share of HIV-infected children in NYC is born to Blacks (which make up 25% of the population, but 58% of the HIV-infected children) and Hispanics (which make up 28% of the population, but 34% of HIV-infected children). Injection drug use by the mother, or being the sex partner of an IV drug user, accounts for 46% of HIV-infected children. In 41% of the cases, the maternal risk factor is not known (214:9).

Since 1981, 1,841 adolescents were first diagnosed with HIV/AIDS between 13 and 19 years of age (214:16)¹. Of these, 1,028 (56%) are male and 813 (44%) are female. Overall, for 14%, injection drug use is the HIV transmission risk factor. The most common risk factor for males is sex with other men (51%). For females, an unspecified risk factor is most common (49%), followed by heterosexual sex (36%). A disproportionate share of HIV-infected NYC adolescents is Black (which make up 25% of the population, but 50% of the HIV-infected adolescents) and Hispanic (which make up 28% of the population, but 35% of HIV-infected adolescents). Eighty percent of the adolescents first diagnosed with HIV between 13 and 19 years of age are still alive.

By the end of 2003, adults 50 years old or older constituted 18% of adults living with AIDS in NYC (224:2). The proportion of persons diagnosed with AIDS in NYC who are age 50 and older is increasing, as is the proportion of this group who are women. Care must be taken, however, in interpreting these results as they may reflect more the fact that AIDS diagnoses are being delayed in the HAART era, rather than the fact that people are becoming infected at an older age (222:19).

¹Among 1,206 adolescents diagnosed with AIDS, 63% were diagnosed solely on the basis of a CD4 cell count under 200 cells/mm³.

Currently the majority of both older men and women diagnosed and living with AIDS are people of color (224:10).

In April 2004, evaluators of the New York EMA's Minority AIDS Initiative reported on results of Title I funded treatment education and adherence programs targeting minority populations in 12 community-based agencies (213). Information from participants in treatment education and adherence programs indicate program effectiveness in terms of improved adherence to treatments, improved CD4 counts, and improved viral loads. The evaluators concluded that better adherence leads to better health; that those with the poorest CD4 counts benefit the most; that those who benefit the most are those who are initially in the poorest health; that if programs are able to increase adherence to treatment, the health of the participants will improve; and that participants benefit quickly and continue to benefit if they remain in the program.

A July 2004 CHAIN study (215:2-3) examined the relationship between social, behavioral and service factors and treatment success. The researchers found that combination-therapy-experienced CHAIN participants reported treatment success (viral loads <400) at the time of their last interview; that currently being on HAART and being completely adherent to HAART were the most important factors associated with treatment success; and that "drug holidays," or treatment interruption, were associated with a significant reduction in treatment success. The study found that the quality of medical care, but not the use of ancillary services, was associated with treatment success, but cautioned that the amount of missing viral load data made definitive conclusions premature. The study also revealed minimal and uncertain association between treatment success and other independent factors, although there was some indication that unstable housing and younger age were associated with reduced treatment success.

A July 2004 CHAIN gaps study (217) ranked the top 5 service gaps for the entire CHAIN cohort as:

- 1) alcohol or drug treatment (50% gap);
- 2) patient/provider communications (38% gap);
- 3) comprehensive case management (30% gap);
- 4) comprehensive medical care (24% gap); and
- 5) professional mental health services (23% gap).

The gaps study also found that individuals who had a comprehensive case management service gap were more likely to have significant service gaps in comprehensive medical care, supportive mental health services, financial and permanent housing, and transportation. With respect to subgroup differences in terms of access to case management services, the only statistically significant difference existed among women, who were more likely to experience a service gap than men.

More sophisticated analysis using the gap data revealed that individuals with very low mental health scores (those with clinically relevant mental symptoms) were more likely to experience comprehensive medical care service gaps and financial housing gaps; individuals with less than a high school education or with annual household incomes below \$10,000 were more likely to experience medical communication and financial housing service gaps; younger individuals (20-30 years old) were more likely to experience permanent housing service gaps; and women were more likely than men to experience treatment adherence and comprehensive case management service gaps, whereas men were more likely than women to experience professional mental health service gaps.

Two formal processes occurred in mid-2004 to gather input from consumers of HIV/AIDS services in New York. In the spring, consumer advisory boards were surveyed regarding the need for HIV services. This study found somewhat different gaps than those identified by the CHAIN gap study. These included housing, legal services, food/nutrition, home care/supportive services, and transportation. This study revealed that 90% of the respondents were either “very satisfied” or “satisfied” with Title I services.

In summer 2004, focus groups of people living with HIV/AIDS in New York were conducted to contribute to a national project to gather input regarding reauthorization of the CARE Act, set to occur in 2005. These focus groups identified the need for the following services as part of the CARE Act reauthorization: full funding for ADAP; increased access to housing; assistance for workforce re-entry; expanded mental health services; and more dental services. Of these focus groups, one was of Spanish-speakers. Spanish-speaking participants additionally identified the need for greater outreach; expanded support group services; and enhanced translation and cultural competency training.

Regarding the HIV/AIDS population 50 years of age and older, a HRSA/HAB report (223:24-25) recommended that age-specific and culturally appropriate HIV prevention and treatment programs be designed and implemented; that service strategies consider not only infected and high risk seniors, but seniors who live with or are family caregivers for someone with HIV/AIDS; and that effective strategies for dealing with the 50+ population need to help to dispel the stigma of HIV/AIDS.

In 2001, the New York State Department of Health AIDS Institute was awarded a contract through the HIV Health and Human Services Planning Council of New York City to measure the quality of health and supportive services provided under Title I. Summary findings from selected areas examined the HIV Quality Management Program include:

- *Primary Care Data Collected by an External Chart Review (2001–2002):* Aggregate scores remained fairly constant between 2001 and 2002 for most indicators including appropriate management of ARV therapy, TB screening, pelvic examinations, viral load monitoring, and adherence assessments.

- *Primary Care Data Collected by Agencies (2001–2002)*: Aggregate scores remained fairly constant between 2001 and 2002, in most cases largely mirroring scores obtained through external chart reviews conducted by the external reviewers.
- *Treatment Education/Adherence Reviews (2001-2003)*: In almost all areas, Treatment Education/Adherence providers improved from 2001 to 2002, and similarly from 2002 to 2003.
- *Mental Health Reviews (2002 – 2003)*: Scores in most areas for most facilities were high in 2003. In addition, most facilities showed improvements in these areas from 2002 to 2003 reviews.
- *Case Management (2003)*: Facilities scored quite high in most areas. The area of greatest weakness, similar to other program areas, was in coordination of care.

Section III. Updated Epidemiological Data

The New York City Department of Health and Mental Hygiene publishes a semiannual *Pediatric and Adolescent HIV/AIDS* report and a quarterly *HIV Epidemiology Program Report*. The most recently available versions of these documents (June 2004 and July 2004, respectively) were reviewed in preparing this *Addendum*. The *Needs Assessment Update* covered data from December 2003 through January 2004. During the six-month period that elapsed between the earlier and later versions, most of the relevant statistics changed, but only slightly. The *Addendum* does not include these minor statistical changes, but focuses on information presented in these and other pertinent documents that was not included in the *Needs Assessment Update*. A complete update of all epidemiological data will be included in the upcoming *New York EMA Comprehensive Strategic Plan for HIV/AIDS Services 2005-2008*.

Pediatric HIV/AIDS Data

Pediatric HIV/AIDS surveillance in NYC measures trends in prevention of perinatal HIV transmission, trends in perinatal HIV transmission rates, and morbidity and mortality of HIV infected children who were first diagnosed with HIV infection before 13 years of age.

Table 1 shows the HIV status of children born to HIV-infected women in NYC, as of the end of 2003 (214:8). Of the 9,627 children born to HIV-infected women, 3,766 were HIV-infected. An additional 65 New York City children have been infected through contaminated blood products (not reflected in Table 1).

Table 1: HIV Status of Children Born to HIV-Infected Women, as of Dec. 31, 2003, NYC

Current HIV status of Child	N
HIV-infected, non-AIDS (a)	1,562
AIDS	2,204
Diagnosed before 13 years	2,028
Diagnosed at 13 years or older	176
Total HIV-infected	3,766
HIV-uninfected(b)	4,625
Indeterminate ^(b)	1,236
Total Children	9,627

^(a) Reporting of all citywide HIV cases is not yet complete.

^(b) Identified from the 22 IRB-approved Expanded Pediatric HIV/AIDS Surveillance sites only.

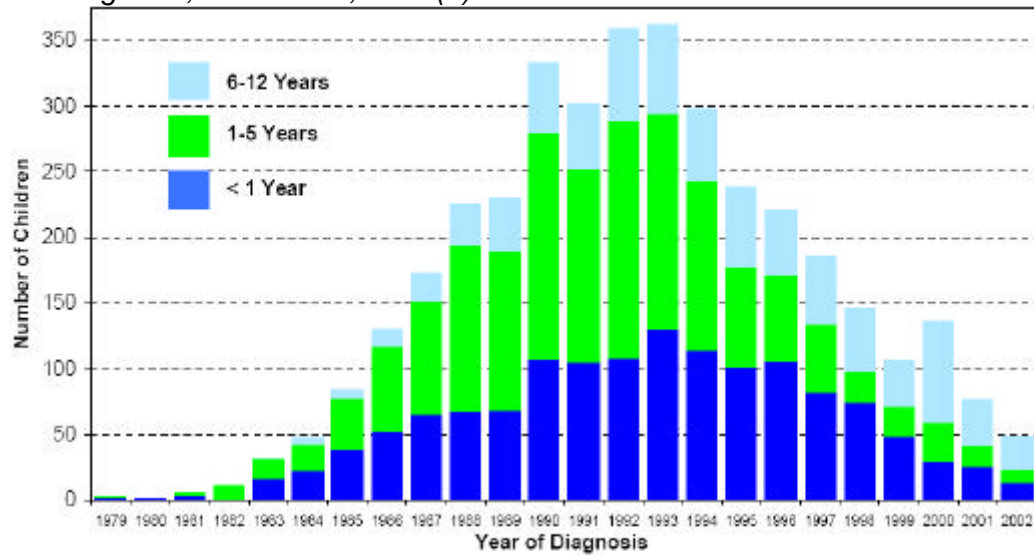
Table 2 shows the demographics of 3,766 perinatally HIV-infected children and maternal HIV risk factors in NYC, as of the end of 2003 (214:9). These data reveal that a disproportionate share of HIV-infected children is born to Blacks (which make up 25% of the total NYC population, but 58% of the HIV-infected children) and Hispanics (which make up 28% of the population, but 34% of HIV-infected children). Injection drug use by the mother, or being the sex partner of an IV drug user, accounts for 46% of HIV-infected children. In 41% of the cases, the maternal risk factor is not known.

Table 2: Demographics of Perinatally HIV-Infected Children (N=3,766) and Maternal Risk Factors, as of December 31, 2003, NYC

Sex	Male	1,858	49%
	Female	1,908	51%
Borough of Residence at Diagnosis	Bronx	1,121	30%
	Brooklyn	1,227	33%
	Manhattan	696	18%
	Queens	476	13%
	Staten Island	78	2%
	Outside NYC	68	2%
	Unknown	100	3%
Race/Ethnicity	Black	2,185	58%
	Hispanic	1,299	34%
	White	234	6%
	Asian/Pacific Islander	15	<1%
	Other/Unknown	33	1%
Maternal HIV Risk	Injection Drug Use (IDU)	1,315	35%
	Sex partner of an IDU man ^(a)	407	11%
	Sex partner of man with HIV/AIDS, or with hemophilia, or in receipt of blood products, or a bisexual man ^(a)	452	12%
	Receipt of blood products	34	1%
	Not specified	1,558	41%

^(a) Maternal HIV risk factors that constitute heterosexual risk.

Figure 1: Age at HIV Diagnosis of Perinatally HIV-infected Children (N=3,766) by Year of Diagnosis, 1979–2002, NYC (a)



Age at Diagnosis	Pre-1990	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	Total
<1 Year	340	107	105	108	130	114	101	108	82	74	48	30	26	14	1,385
1-5 Years	485	173	147	181	164	129	77	66	52	24	23	29	15	10	1,575
6-12 Years	118	53	50	70	68	55	60	49	52	48	35	77	35	24	794
Total	943	333	302	359	362	298	238	221	186	146	106	136	76	48	3,754 ^(a)

^(a) Data are incomplete for 2003 due to reporting lag. The 12 cases diagnosed in 2003 are not included in the figure and table.

Figure 1 shows the number of HIV-infected children in NYC by year of initial diagnosis of HIV infection (214:10). The number of diagnoses peaked at 362 children in 1993. Decline in HIV diagnoses among children under 13 years of age is due to decreasing numbers of HIV-infected women delivering HIV+ babies and increasing use of prenatal antiretroviral therapies to prevent transmission (214:10).

Table 3 shows that the number of AIDS-defining conditions dropped dramatically in NYC after 1995 (from 1,558 conditions diagnoses in the 1990-1995 period to 358 conditions diagnosed in the 1996-1998 period), paralleling the drop in newly diagnosed children with AIDS (214:12). From 1999-2002, 40% of AIDS diagnoses were based solely on CD4 cell count under 200 cells/mm³ among those >13 years of age.

Table 3: Cumulative AIDS-Defining Conditions of 2,204 Perinatally HIV-Infected Persons with AIDS^(a), by Year of Diagnosis^(b), 1979–2002, NYC

	1979-1989	1990-1995	1996-1998	1999-2002	Total	%
<i>Pneumocystis jiroveci pneumonia</i> ^(c)	290	376	58	24	748	26
<i>Lymphoid interstitial pneumonia</i>	178	293	44	6	521	18
<i>Mycobacterium avium complex & other species disease</i>	52	172	52	24	300	10
<i>HIV encephalopathy</i>	47	163	45	20	275	10
<i>Recurrent bacterial infections</i>	125	116	20	7	268	9
<i>Esophageal candidiasis</i>	50	83	21	22	176	6
<i>Wasting syndrome</i>	40	95	26	12	173	6
<i>Cytomegalovirus disease</i>	66	63	13	5	147	5
<i>Chronic mucocutaneous herpes simplex</i>	32	50	9	4	95	3
<i>Chronic intestinal cryptosporidiosis</i>	24	32	8	1	65	2
<i>Pulmonary candidiasis</i>	23	19	1	4	47	2
<i>Cytomegalovirus retinitis</i>	4	17	7	7	35	1
<i>Extrapulmonary tuberculosis</i>	7	10	5	4	26	1
<i>Cryptococcosis</i>	4	12	3	2	21	1
<i>Burkitt's lymphoma</i>	9	8	2	0	19	1
<i>Toxoplasmosis, brain</i>	7	6	4	1	18	1
<i>Lymphoma, brain</i>	7	4	1	2	14	<1
<i>Immunoblastic lymphoma</i>	1	4	5	2	12	<1
<i>Progressive multifocal leukoencephalopathy</i>	1	3	2	2	8	<1
<i>Recurrent pneumonia</i> ^(d)	NA	2	1	1	4	<1
<i>Kaposi's sarcoma</i>	0	3	0	0	3	<1
<i>Histoplasmosis</i>	1	0	1	0	2	<1
<i>Pulmonary tuberculosis</i> ^(d)	NA	1	0	0	1	<1
<i>CD4 cell count <200 cells/mm³</i> ^(d)	NA	26	30	102	158	6
TOTAL	968	1,558	358	252	3,136	

NA=not applicable

^(a) Some have more than one AIDS-defining condition.

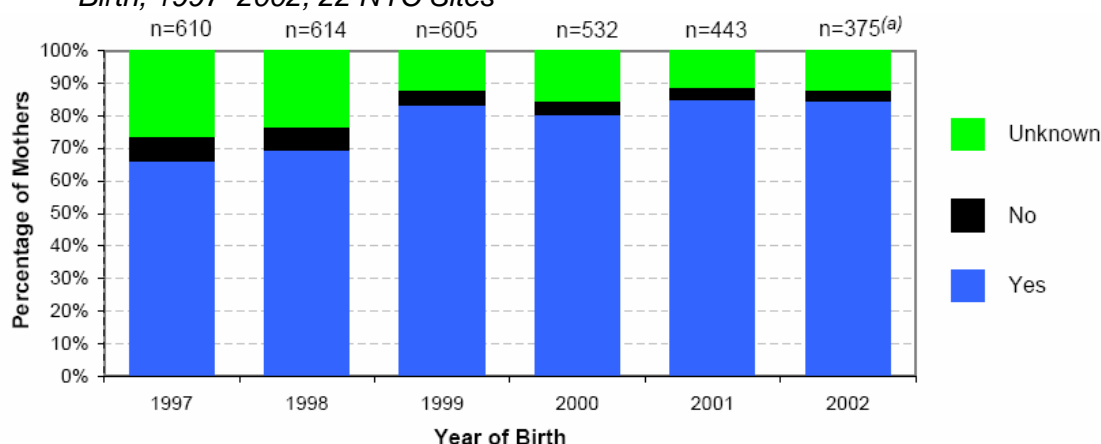
^(b) Data are incomplete for 2003 due to reporting lag. The 4 AIDS-defining conditions diagnosed in 2003 are not included in this table: 1 esophageal candidiasis, 1 HIV encephalopathy, 1 recurrent bacterial infections, and 1 Burkitt's lymphoma.

^(c) Previously named *Pneumocystis carinii pneumonia*

^(d) In 1993, the CDC AIDS case definition was expanded to include CD4 cell counts <200 cells/mm³, pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer in adolescents and adults ≥13 years of age.

The Expanded Pediatric HIV/AIDS Surveillance program of NYC DOHMH collects information on all perinatally exposed children at 22 sites that care for an estimated two-thirds of children exposed to, and infected with, HIV in NYC. Figure 2 shows that of the 2,625 HIV-infected women (82%) with prenatal care data cared for at these sites, 93% had prenatal care (214:14). Among women in prenatal care, at least 90% of women were diagnosed with HIV before delivery.

Figure 2: Proportion of HIV-Infected Women who Received Prenatal Care, by Year of Infant Birth, 1997–2002, 22 NYC Sites^(a)



^(a) Enrollment decreased to 19 sites in 2002.

Table 4 examines the relationship between prenatal, intrapartum, and neonatal antiretroviral prescriptions and infants' HIV infection status at the 22 Expanded Pediatric HIV/AIDS Surveillance sites (214:15). The 2,059 infants are among 3,179 infants born between 1997-2002 in NYC for who complete information on maternal and neonatal antiretroviral regimens are available. Transmission rates were lowest among deliveries with prenatal zidovudine (ZDV) with other antiretroviral therapy (ART) in addition to intrapartum and neonatal ZDV.

Table 4: Perinatal HIV Transmission Rates by Prenatal, Intrapartum, and Neonatal Antiretroviral Regimen Evaluated for 2,059 of the 3,179 Infants Born 1997–2002, 22 NYC Sites^(a)

Timing of ART use	N	% Infected	% Uninfected	% Indeterminate	OR (95% CI) ^(b)
Prenatal ZDV with other ART ^(c) plus intrapartum and neonatal ZDV	997	2	77	21	0.09 (0.05-0.16)
Prenatal, intrapartum and neonatal ZDV	727	5	77	18	0.22 (0.13-0.35)
Neonatal ZDV only (started within 24 hours of birth)	94	9	64	27	0.48 (0.20-1.09)
None (no ART) ^(d)	241	19	61	20	Referent

ART=antiretroviral therapy; ZDV=zidovudine; OR=Odds Ratio

^(a) Enrollment decreased to 19 sites in 2002.

^(b) ORs were calculated based on the comparison of HIV-infected and HIV-uninfected infants

^(c) Reverse transcriptase inhibitors and/or protease inhibitors.

^(d) All infants were evaluated for HIV exposure within 2 months of birth.

Table 5 shows cumulative data reported to the NYC DOHMH since 1981 through December 2003, on 1,841 adolescents first diagnosed with HIV/AIDS between 13 and 19 years of age (214:16).² Of these individuals, 1,028 (56%) are males and 813 (44%) are females. Injection drug use as the HIV transmission risk factor is approximately the same for both men (15%) and women (14%). The most common risk factor for males is sex with other men (51%). For females, an unspecified risk factor is most common (49%), followed by heterosexual sex (36%).

These data reveal that a disproportionate share of HIV-infected adolescents is Black (who make up 25% of the total NYC population, but 50% of the HIV-infected adolescents) and Hispanic (who make up 28% of the population, but 35% of HIV-infected adolescents). Eighty percent of the adolescents first diagnosed with HIV between 13 and 19 years of age are still alive; 20% are dead.

Table 5: Cumulative Data of Adolescents First Diagnosed with HIV Between 13 and 19 Years of Age (N=1,841), by Current HIV Status, HIV Transmission Risks and Demographics as of December 31, 2003.

		Male			Female			TOTAL
		HIV	AIDS	Total	HIV	AIDS	Total	
HIV Transmission Risks	<i>Men who have sex with men</i>	174	349	523 (51%)	N/A	N/A	N/A	523 (28%)
	<i>Injection drug use</i>	19	135	154 (15%)	14	94	108 (13%)	262 (14%)
	<i>Heterosexual</i>	20	27	47 (4.5%)	98	198	296 (36%)	343 (19%)
	<i>Receipt of blood products</i>	2	45	47 (4.5%)	1	11	12 (2%)	59 (3%)
	<i>Unspecified</i>	99	158	257 (25%)	208	189	397 (49%)	654 (36%)
Race Ethnicity	<i>Black</i>	144	301	445 (43%)	195	285	480 (59%)	925 (50%)
	<i>Hispanic</i>	116	270	386 (37%)	93	165	258 (32%)	644 (35%)
	<i>White</i>	45	138	183 (18%)	23	36	59 (7%)	242 (13%)
	<i>Asian/Pacific Islander</i>	4	4	8 (1%)	4	3	7 (1%)	15 (1%)
	<i>Other/Unknown</i>	5	1	6 (1%)	6	3	9 (1%)	15 (1%)
Borough of Residence at Diagnosis	<i>Bronx</i>	88	145	233 (23%)	99	150	249 (31%)	482 (26%)
	<i>Brooklyn</i>	79	196	275 (27%)	101	176	277 (34%)	552 (30%)
	<i>Manhattan</i>	86	193	279 (27%)	65	89	154 (19%)	433 (24%)
	<i>Queens</i>	41	109	150 (14%)	37	56	93 (11%)	243 (13%)
	<i>Staten Island</i>	7	20	27 (3%)	9	9	18 (2%)	45 (2%)
	<i>Other/Unknown</i>	13	51	64 (6%)	10	12	22 (3%)	86 (5%)
Survival Status	<i>Dead</i>	1	225	226 (22%)	2	147	149 (18%)	375 (20%)
	<i>Alive</i>	313	489	802 (78%)	319	345	664 (82%)	1,466 (80%)
TOTAL		314	714	1,028	321	492	813	1,841

² Among 1,206 adolescents diagnosed with AIDS, 63% were diagnosed solely on the basis of a CD4 cell count under 200 cells/mm³.

Persons 50 Years of Age and Older

By the end of 2003, adults 50 years old or older constituted 18% of adults living with AIDS in NYC (224:2). As shown in *Figures 3 and 4*, the proportion of persons diagnosed with AIDS in NYC who are age 50 and older is increasing and the proportion of this group who are women is also increasing. Care must be taken, however, in interpreting these results as they may reflect more the fact that AIDS diagnoses are being delayed as a result of access to care and treatment, rather than the fact that people are becoming infected at an older age (222:19).

Figure 3: Distribution of Adult NYC AIDS Cases in Men by Age Group and Year of Diagnosis

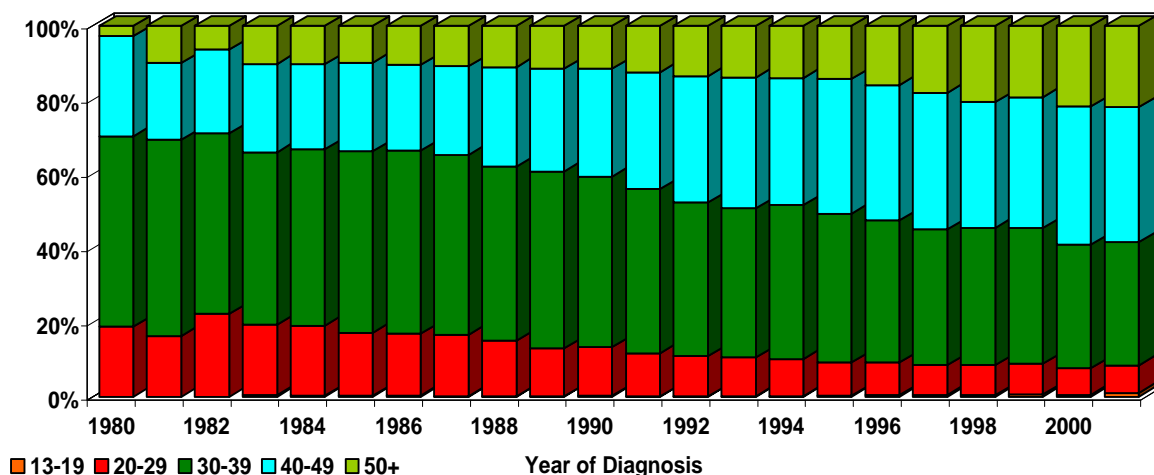
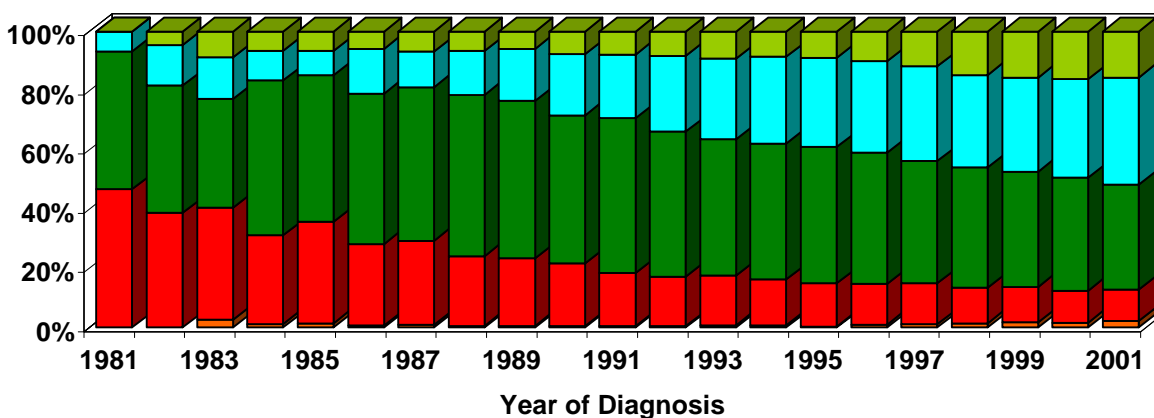


Figure 4: Distribution of Adult NYC AIDS Cases in Women by Age Group and Year of Diagnosis



As shown in *Figures 4 and 5*, currently the majority and a disproportionate share of both older men and women diagnosed and living with AIDS are people of color (224:10). Blacks comprise 25% of the population as a whole in NYC, but 43% of the men living with AIDS and 55% of the women living with AIDS. Hispanics comprise 28% of the population as a whole, but 30% of the men and 33% of the women living with AIDS.

Figure 5: Male PLWA Age 50+ by Race/Ethnicity as of December 2002³

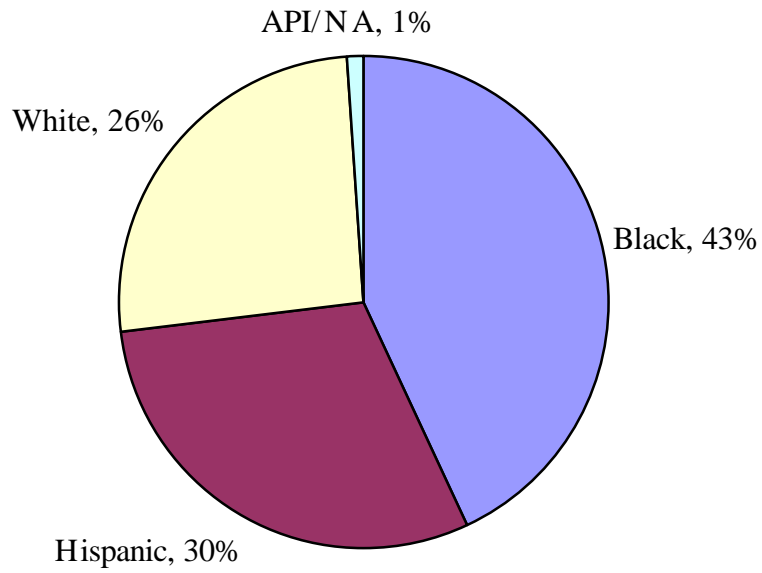
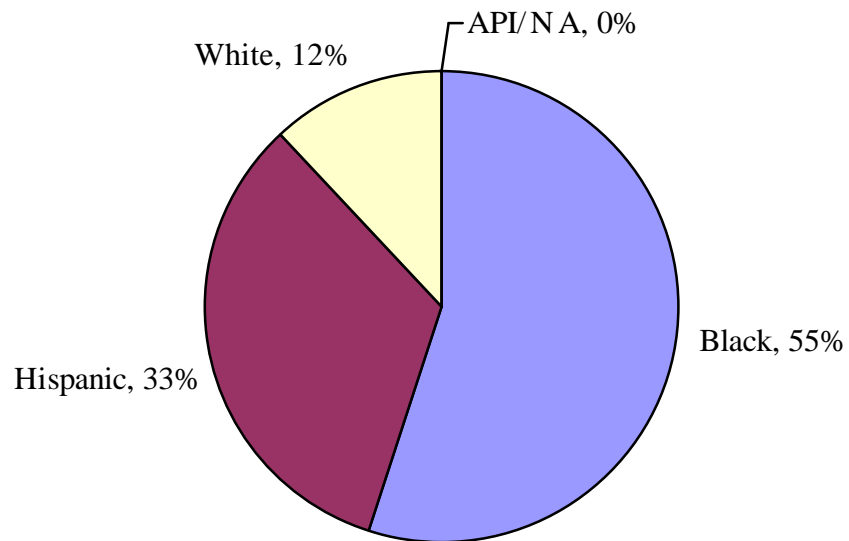


Figure 6: Female PLWA Age 50+ by Race/Ethnicity as of December 2002



³ API – Asian and Pacific Islanders

Section IV. Community Health Profiles

In 2003, the New York City Department of Health and Mental Hygiene published *Community Health Profiles* for 42 New York City communities. The profiles highlight important health issues facing the residents of New York City's diverse communities. Preventable causes of illness and death including HIV/AIDS are a special focus of the profiles. All profiles can be accessed by visiting www.nyc.gov/health.

The general health and HIV/AIDS-related data included in the profiles provide useful information for the purposes of HIV/AIDS planning. This section of the *Addendum* describes the Community Health Profiles and presents a selection of relevant data taken from all 42 profiles.

Overview of the Community Health Profiles

Each of the communities in New York City's five boroughs has its own profile. Geographic definitions of neighborhoods are based on zip code aggregations from the United Hospital Fund. Data sources are from a wide variety of local, state, and national datasets. Ranks in each category were computed by combining several standardized (z-scores) measures within the following categories:

- General health;
- Maternal and child health;
- Infectious diseases;
- Chronic diseases;
- Prevention in doctors' offices; and
- Access to medical care.

A consistent format is used in each of the profiles and includes:

- Snapshots from the U.S. Census;
- Report card on health;
- How residents rate their own health;
- Major causes of death and hospital admissions;
- The health of mothers and children;
- Targets for prevention;
- Medical care: opportunities for prevention, and
- Vulnerable populations.

The following two tables present a selection of data from the profiles. Both tables are organized by borough, neighborhood, and zip codes. Where available, citywide data is indicated at the top of the table to provide for comparison. *Table 6* presents general health related data that are relevant to HIV/AIDS planning by community. This includes population, age, race/ethnicity, and poverty data and other information regarding medical care. It also shows the community's ranking in access to care. *Table 7* presents HIV/AIDS-related data, again by neighborhood and zip code, including an overall infectious disease rating for the community as well as AIDS mortality data and the number of new HIV diagnoses and total number of persons living with HIV/AIDS in the community.

Table 6. Selected General Health-Related Data for 42 New York City Communities, 2003⁴

Community	Zip Codes	Population 2002	Predominate age compared to NYC	Predominate race/ethnicity	Percent of residents who are foreign born	Percent of women who receive late or no prenatal care	Number (and %) of residents with no health coverage	Number (and %) of residents who did not get needed health care	Number (and %) of residents who report no doctor	Community's rank in access to care rank ⁵	Percent living in poverty
Citywide		8,085,321	See footnote ⁶	See footnote ⁷	36%	30% ⁸	12%	10%	25%	Varies	21%
BROOKLYN											
Greenpoint	11222, 11211	124,449	Slightly younger	White, Hispanic	34%	35%	18,000 (21%)	11,000 (13%)	32,000 (36%)	Below average	34%
Sunset Park	11232, 11220	120,441	Slightly younger	Hispanic, Asian	49%	17%	11,000 (12%)	8,000 (9%)	25,000 (29%)	Average	28%
Bushwick/Williamsburg	11206, 11237, 11221	194,305	Younger	Hispanic , African American	27%	34%	18,000 (14%)	18,500 (14%)	47,500 (36%)	Below average	38%
Northwest Brooklyn (Brooklyn Heights, Carroll Gardens, Clinton Hill, Downtown, Fort Greene, Park Slope, Red Hook)	11215, 11201, 11205, 11217, 11231	214,696	Young adults	White	17%	22%	17,000 (10%)	8,700 (5%)	40,000 (23%)	High	20%
Central Brooklyn (Bedford-Stuyvesant, Crown Heights, Prospect Heights, Brownsville)	11238, 11216, 11213, 11233, 11212	317,296	Younger	African American	29%	36%	29,000 (13%)	30,000 (14%)	58,000 (26%)	Below average	31%
Flatbush (East Flatbush, Midwood, Prospect, Leffert Gardens)	11226, 11225, 11203, 11210	316,734	Younger	African American	51%	37%	29,000 (13%)	23,000 (10%)	49,000 (22%)	Average	21%
East New York/New Lots (Cypress Hills)	11207, 11208	173,716	Younger	African American, Hispanic	33%	37%	16,000 (14%)	16,000 (14%)	36,000 (32%)	Below average	34%
Borough Park	11218, 11219, 11204, 11230	324,411	Children and older adults	White, Asian	45%	23%	34,000 (15%)	24,000 (10%)	49,000 (21%)	Average	25%
Southwest Brooklyn (Bay Ridge, Bensonhurst, Dyker Heights)	11209, 11228, 11214	194,558	Older	White, Asian	40%	20%	18,000 (11%)	14,000 (9%)	41,000 (26%)	Average	16%

⁴ Represents time period from January 1, 2002 through December 31, 2002.

⁵ Below average=bottom 10 communities, Average = middle 22 communities, Above average = top 10 communities

⁶ Age distribution for all of New York City: ages 0-17: 24%, ages 18-64: 64%, aged 65 and over: 12%

⁷ Race/ethnicity distribution for New York City: White: 35%, Hispanic: 27%, African American: 25%, Asian: 10%, Other: 3%

⁸ The national goal for the proportion of women who receive late or no prenatal care is 10%.

Table 6. Selected General Health-Related Data for 42 New York City Communities, 2003¹

Community	Zip Codes	Population 2002	Predominate age compared to NYC	Predominate race/ethnicity	Percent of residents who are foreign born	Percent of women who receive late or no prenatal care	Number (and %) of residents with no health coverage	Number (and %) of residents who did not get needed health care	Number (and %) of residents who report no doctor	Community's rank in access to care rank ⁵	Percent living in poverty
Citywide		8,085,321	See footnote ⁶	See footnote ⁷	36%	30% ⁸	12%	10%	25%	Varies	21%
BROOKLYN (con't)											
Southern Brooklyn (Brighton Beach, Coney Island, Sheepshead Bay)	11229, 11223, 11235, 11224	286,901	Slightly older	White	47%	29%	27,000 (12%)	21,000 (10%)	55,000 (24%)	Average	22%
Canarsie/Flatlands (Starrett City)	11239, 11236, 11234	197,819	Slightly younger	African American	37%	29%	18,000 (13%)	15,000 (10%)	32,000 (22%)	Average	14%
BRONX											
Central Bronx (Bathgate, Bronx Park South, Crotona, Morris Heights, Mount Hope, Tremont)	10453, 10457, 10460	199,530	Younger	Hispanic, African American	30%	33%	12,000 (9%)	12,000 (9%)	43,000 (33%)	Average	41%
Fordham/Bronx Park (Bedford Park, Belmont, Kingsbridge Heights, Norwood, University Heights)	10467, 10468, 10458	250,491	Younger	Hispanic	35%	32%	27,000 (16%)	22,000 (13%)	46,000 (27%)	Below Average	33%
Highbridge/Morrisiana	10452, 10456, 10451	189,755	Younger	Hispanic, African American	30%	35%	11,000 (9%)	11,000 (9%)	41,000 (33%)	Average	42%
Hunts Point/Mott Haven	10459, 10455, 10474, 10454	122,875	Younger	Hispanic	25%	37%	7,000 (9%)	7,000 (9%)	26,000 (33%)	Average	45%
Kingsbridge/Riverdale	10471, 10463	88,989	Older	White, Hispanic	30%	23%	5,000 (7%)	5,000 (7%)	19,000 (28%)	Average	15%
Northeast Bronx (Co-op City, Eastchester, Wakefield, Williamsbridge, Woodlawn)	10470, 10466, 10469, 10475	185,998	Slightly older	African American	33%	27%	8,000 (6%)	7,000 (5%)	29,000 (21%)	Above average	16%
Southeast Bronx (Bruckner, Castle Hill, City Island, Country Club, Morris Park, Parkchester, Pelham Bay, Soundview, Throgs Neck)	10464, 10461, 10462, 10472, 10473, 10465	290,052	Younger	Hispanic	23%	31%	17,000 (8%)	19,000 (9%)	60,000 (22%)	Average	22%
MANHATTAN											
Inwood/Washington Heights	10031, 10032, 10033, 10034, 10040	270,677	Slightly younger	Hispanic	51%	33%	20,000 (10%)	34,000 (17%)	68,000 (34%)	Below average	31%
East Harlem	10035, 10029	108,092	Slightly younger	Hispanic, African American	21%	38%	7,000 (9%)	10,000 (13%)	21,000 (27%)	Average	38%
Central Harlem (Morningside Heights)	10039, 10030, 10037, 10027,	151,113	Slightly younger	African American	19%	36%	6,600 (6%)	13,000 (12%)	31,000 (28%)	Average	35%

Table 6. Selected General Health-Related Data for 42 New York City Communities, 2003¹

Community	Zip Codes	Population 2002	Predominate age compared to NYC	Predominate race/ethnicity	Percent of residents who are foreign born	Percent of women who receive late or no prenatal care	Number (and %) of residents with no health coverage	Number (and %) of residents who did not get needed health care	Number (and %) of residents who report no doctor	Community's rank in access to care rank ⁵	Percent living in poverty
Citywide		8,085,321	See footnote ⁶	See footnote ⁷	36%	30% ⁸	12%	10%	25%	Varies	21%
	10026										
MANHATTAN (con't)											
Upper West Side	10025, 10024, 10023	222,109	Older	White	22%	15%	17,000 (9%)	12,000 (6%)	41,000 (21%)	Above average	11%
Upper East Side	10128, 10028, 10021, 10044	218,167	Older	White	22%	9%	9,000 (5%)	2,000 (1%)	45,000 (23%)	Above average	7%
Chelsea/Clinton	10019, 10036, 10018, 10001, 10011, 10020	122,998	Older	White	25%	23%	13,000 (12%)	10,000 (9%)	28,000 (25%)	Average	14%
Gramercy Park/Murray Hill	10022, 10017, 10016, 10010	124,477	Younger	White	25%	15%	5,000 (5%)	1,000 (1%)	27,000 (23%)	Above average	8%
Greenwich Village/Soho (Tribeca)	10014, 10013, 10012	83,709	Young	White, Asian	28%	20%	9,000 (12%)	7,000 (9%)	19,000 (25%)	Average	13%
Lower East Side (Chinatown, East Village)	10003, 10009, 10002	197,138	Young adults	Asian, White	35%	33%	21,000 (12%)	14,000 (8%)	44,000 (27%)	Average	23%
Lower Manhattan	10007, 10280, 10006, 10038, 10005, 10004	30,895	Older	White, Asian	28%	22%	1,000 (4%)	700 (3%)	3,500 (13%)	Above average	17%
QUEENS											
Northeast Queens (Bayside, Douglaston, Little Neck, Oakland Gardens)	11361, 11362, 11363, 11364	88,164	Slightly older	White, Asian	35%	22%	9,500 (14%)	4,000 (6%)	13,500 (19%)	Average	7%
North Queens (Auburndale, Bay Terrace, Clearview, College Point, Flushing, Whitestone)	11360, 11354, 11355, 11356, 11357, 1357, 11358,	255,542	Older	White, Asian	50%	29%	33,000 (16%)	26,000 (13%)	41,000 (20%)	Below average	13%
Central Queens (Fresh Meadows, Hillcrest, Kew Gardens)	11365, 11366, 11367	93,148	Slightly older	White, Asian	39%	28%	10,000 (14%)	4,000 (6%)	14,000 (19%)	Average	10%
Jamaica	11423, 11432, 11435, 11433, 11412, 11434, 11436	285,568	Children and older	African American	38%	34%	21,000 (10%)	23,000 (11%)	53,000 (25%)	Average	16%
Northwest Queens (Astoria, Long Island City, Sunnyside)	11101, 11102, 11103, 11104,	220,960	Children and older adults	White, Asian	51%	34%	33,000 (19%)	27,000 (15%)	52,000 (29%)	Below average	20%

Table 6. Selected General Health-Related Data for 42 New York City Communities, 2003¹

Community	Zip Codes	Population 2002	Predominate age compared to NYC	Predominate race/ethnicity	Percent of residents who are foreign born	Percent of women who receive late or no prenatal care	Number (and %) of residents with no health coverage	Number (and %) of residents who did not get needed health care	Number (and %) of residents who report no doctor	Community's rank in access to care rank ⁵	Percent living in poverty
Citywide		8,085,321	See footnote ⁶	See footnote ⁷	36%	30% ⁸	12%	10%	25%	Varies	21%
	11105, 11106										
QUEENS (con't)											
West Central Queens (Forest Hills, Glendale, Middle Village, Rego Park, Ridgewood)	11374, 11375, 11379, 11385	240,901	Children and older adults	White	44%	28%	29,000 (15%)	13,000 (7%)	44,000 (23%)	Average	13%
Rockaways	11691, 11692, 11693, 11694, 11697, 11695	106,738	Children and older adults	African American	24%	45%	8,000 (11%)	6,000 (8%)	17,000 (23%)	Average	8%
Southeast Queens (Cambria Heights, Glen Oaks, Laurelton, Queens Village, Rosedale)	11004, 11005, 11426, 11427, 11428, 11429, 11411, 11413, 11422	203,670	Children and older adults	African American	39%	32%	17,000 (11%)	8,500 (6%)	34,000 (22%)	Above average	7%
Southwest Queens (Howard Beach, Kew Gardens, Ozone Park, Richmond Hill, Woodhaven)	11414, 11415, 11416, 11417, 11418, 11419, 11420, 11421	269,952	Children and older adults	Asian, multiple race/ ethnicities	44%	33%	33,000 (16%)	19,000 (9%)	46,000 (23%)	Below average	13%
West Queens (Corona, Elmhurst, Jackson Heights, Maspeth, Woodside)	11368, 11369, 11370, 11372, 11373, 11377, 11378	477,516	Children and older adults	Hispanic, Asian	59%	42%	69,000 (19%)	55,000 (15%)	108,000 (29%)	Below average	18%
STATEN ISLAND											
Port Richmond	10302, 10303, 10310	62,788	Younger	White	18%	28%	4,800 (11%)	2,900 (7%)	9,400 (21%)	Above average	17%
South Beach (Annandale, Eltingville, Great Kills, Huguenot, South Beach, Tottenville)	10306, 10307, 10308, 10309, 10312	179,892	Older and younger adults	White	12%	11%	7,000 (5%)	3,000 (3%)	16,000 (12%)	Above average	5%
Stapleton/St. George	10301, 10304, 10305	116,227	Children and older adults	White	22%	26%	9,000 (11%)	6,000 (7%)	19,000 (21%)	Average	16%
Mid-Island (Mariner's Harbor, New Springville, Travis, Willowbrook)	10314	84,821	Children and older adults	White	17%	15%	3,000 (5%)	1,700 (3%)	7,000 (12%)	Above average	7%

Table 7. Selected HIV/AIDS-Related Data for 42 New York City Communities, 2003⁹¹⁰

Community	Zip Codes	Infectious diseases report card	Number of AIDS deaths	AIDS death rate per 100,000 people	AIDS death rate compared to NYC	AIDS potential years of life lost	AIDS potential years of life lost as a percent of total	Number of persons newly diagnosed with HIV 2001	People living with HIV/AIDS 2001	Percent of adults at high HIV risk
Citywide	Varies	Varies	1,712	22	Varies	Varies	Varies	5,020	83,249	5%
BROOKLYN										
Greenpoint	11211, 11222	Average	22	21	5% lower	608	9%	62	687	5%
Sunset Park	11232, 11220	Above average	-	-	-	-	-	37	543	3%
Bushwick/Williamsburg	11206, 11237, 11221	Below average	83	50	2 times higher	2,541	14%	252	2,356	7%
Northwest Brooklyn (Brooklyn Heights, Carroll Gardens, Clinton Hill, Downtown, Fort Greene, Park Slope, Red Hook)	11201, 11205, 11217, 11231, 11215	Middle	60	28	30% higher	1,725	12%	175	2,192	4%
Central Brooklyn (Bedford-Stuyvesant, Crown Heights, Prospect Heights, Brownsville)	11238, 11216, 11213, 11233, 11212	Below average	158	54	2 times higher	4,899	.14%	528	4,146	5%
Flatbush (East Flatbush, Midwood, Prospect, Leffert Gardens)	11225, 11226, 11203, 11210	Below average	76	24	10% higher	-	-	299	2,589	3%
East New York/New Lots (Cypress Hills)	11207, 11208	Below average	66	43	95% higher	2,085	13%	181	1,694	8%
Borough Park	11218, 11219, 11204, 11230	Average	-	-	-	-	-	46	669	4%
Southwest Brooklyn (Bay Ridge, Bensonhurst, Dyker Heights)	11209, 11228, 11214	Above average	-	-	-	-	-	26	363	4%
Canarsie/Flatlands (Starrett City)	11239, 11236, 11234	Average	24	12	45% lower	-	-	96	680	3%
Southern Brooklyn (Brighton Beach, Coney Island, Sheepshead Bay)	11229, 11223, 11235, 11224	Average	28	10	55% lower	-	-	77	767	3%
BRONX										
Central Bronx (Bathgate, Bronx Park South, Crotona, Morris Heights, Mount Hope, Tremont)	10453, 10457, 10460	Average	117	69	3 times higher	3,629	19%	375	3,120	8%

⁹ Community Health Profiles do not report all data for all neighborhoods. A dash (-) is used for data that are not reported in the specific neighborhood's profile.¹⁰ Represents time period from January 1, 2001 through December 31, 2001.

Table 7. Selected HIV/AIDS-Related Data for 42 New York City Communities, 2003⁹¹⁰

Community	Zip Codes	Infectious diseases report card	Number of AIDS deaths	AIDS death rate per 100,000 people	AIDS death rate compared to NYC	AIDS potential years of life lost	AIDS potential years of life lost as a percent of total	Number of persons newly diagnosed with HIV 2001	People living with HIV/AIDS 2001	Percent of adults at high HIV risk
Citywide	Varies	Varies	1,712	22	Varies	Varies	Varies	5,020	83,249	5%
BRONX (con't)										
Highbridge/Morrisiana	10452, 10456, 10451	Below average	118	74	3.5 times higher	3,393	17%	389	3,233	8%
Fordham/Bronx Park (Bedford Park, Belmont, Kingsbridge Heights, Norwood, University Heights)	10467, 10468, 10458	Below average	87	41	90% higher	2,579	15%	293	2,674	6%
Hunts Point/Mott Haven	10459, 10455, 10474, 10454	Below average	70	69	3 times higher	2,188	16%	282	2,087	8%
Kingsbridge/Riverdale	10471, 10463	Average	16	18	15% lower	-	-	26	350	5%
Northeast Bronx (Co-op City, Eastchester, Wakefield, Williamsbridge, Woodlawn)	10470, 10466, 10469, 10475	Average	32	18	15% lower	-	-	102	942	4%
Southeast Bronx (Bruckner, Castle Hill, City Island, Country Club, Morris Park, Parkchester, Pelham Bay, Soundview, Throgs Neck)	10464, 10461, 10462, 10472, 10473, 10465	Average	58	21	5% lower	-	-	229	2,288	8%
MANHATTAN										
Inwood/Washington Heights	10031, 10032, 10033, 10034, 10040	Average	37	14	35% lower	-	-	237	2,465	7%
East Harlem	10035, 10029	Below average	73	76	3.5 times	2,068	17%	196	2,166	9%
Central Harlem (Morningside Heights)	10039, 10030, 10037, 10027, 10026	Below average	89	65	3 times higher	2,563	15%	355	2,956	3%
Upper West Side	10025, 10024, 10023	Average	43	17	20% lower	1,084	11%	198	2,570	4%
Upper East Side	10128, 10028, 10021, 10044	Above average	-	-	-	-	-	66	1,051	4%
Chelsea/Clinton	10019, 10036, 10018, 10001, 10011, 10020	Average	36	27	20% higher	1,020	15%	294	3,981	6%
Gramercy Park/Murray Hill	10022, 10017, 10016, 10010	Middle	17%	12	Lower by 45%	518	9%	99	1,587	4%
Greenwich Village/Soho (TriBeCa)	10014, 10013, 10012	Middle	22	24	10% higher	583	13%	84	1,540	6%
Lower East Side (Chinatown, East Village)	10003, 10009, 10002	Middle	75	37	70% higher	2,100	18%	175	2,482	4%
	10007, 10280, 10006,	Middle	-	-	-	-	-	32	265	12%

Table 7. Selected HIV/AIDS-Related Data for 42 New York City Communities, 2003⁹¹⁰

Community	Zip Codes	Infectious diseases report card	Number of AIDS deaths	AIDS death rate per 100,000 people	AIDS death rate compared to NYC	AIDS potential years of life lost	AIDS potential years of life lost as a percent of total	Number of persons newly diagnosed with HIV 2001	People living with HIV/AIDS 2001	Percent of adults at high HIV risk
Citywide	Varies	Varies	1,712	22	Varies	Varies	Varies	5,020	83,249	5%
Lower Manhattan	10038, 10005, 10004									
QUEENS										
Northeast Queens (Bayside, Douglaston, Little Neck, Oakland Gardens)	11361, 11362, 11363, 11364	Above average	-	-	-	-	-	<10	92	3%
North Queens (Auburndale, Bay Terrace, Clearview, College Point, Flushing, Whitestone)	11354, 11355, 11356, 11357, 11358, 11359, 11360	Above average	-	-	-	-	-	36	483	1%
Central Queens (Fresh Meadows, Hillcrest, Kew Gardens)	11365, 11366, 11367	Above average	-	-	-	-	-	12	157	3%
Jamaica	11423, 11432, 11435, 11433, 11412, 11434, 11436	Average	56	20	5% lower	1,752	9%	201	1,706	4%
Northwest Queens (Astoria, Long Island City, Sunnyside)	11101, 11102, 11103, 11104, 11105, 11106	Average	16	7	65% lower	-	-	83	1,065	8%
West Central Queens (Forest Hills, Glendale, Middle Village, Rego Park, Ridgewood)	11374, 11375, 11379, 11385	Above average	-	-	-	-	-	69	657	4%
Rockaways	11691, 11692, 11693, 11694, 11695, 11697	Average	21	22	Even	-	-	70	535	4%
Southeast Queens (Cambria Heights, Glen Oaks, Laurelton, Queens Village, Rosedale)	11004, 11005, 11411, 11413, 11422, 11426, 11427, 11428, 11429,	Average	15	7	65% lower	-	-	56	689	3%
Southwest Queens (Howard Beach, Kew Gardens, Ozone Park, Richmond Hill, Woodhaven)	11414, 11415, 11416, 11417, 11418, 11419, 11420, 11421	Average	26	10	55% lower	-	-	88	894	6%
West Queens (Corona, Elmhurst, Jackson Heights, Maspeth, Woodside)	11368, 11369, 11370, 11372, 11373, 11377, 11378,	Below average	39	8	65% lower	-	-	223	2,761	8%
STATEN ISLAND										
Port Richmond	10302, 10303, 10310	Above average	-	-	-	-	-	20	258	2%
The South Shore (Annandale, Eltingville, Great Kills, Huguenot, South Beach, Tottenville)	10306, 10307, 10308, 10309, 10312	Above average	-	-	-	-	-	23	239	3%
Stapleton/St. George	10301, 10304, 10305	Average	26	22	-	-	-	56	597	2%

Table 7. Selected HIV/AIDS-Related Data for 42 New York City Communities, 2003⁹¹⁰

Community	Zip Codes	Infectious diseases report card	Number of AIDS deaths	AIDS death rate per 100,000 people	AIDS death rate compared to NYC	AIDS potential years of life lost	AIDS potential years of life lost as a percent of total	Number of persons newly diagnosed with HIV 2001	People living with HIV/AIDS 2001	Percent of adults at high HIV risk
Citywide	Varies	Varies	1,712	22	Varies	Varies	Varies	5,020	83,249	5%
Mid-Island (Mariner's Harbor, New Springville, Travis, Willowbrook)	10314	Above average	-	-	-	-	-	<10	95	3%

Section V. General Information Since the New York Eligible Metropolitan Area HIV/AIDS Needs Assessment Update 2004

Consumer Input

Two formal processes occurred in mid-2004 to gather input from consumers of HIV/AIDS services in New York. In the spring, consumer advisory boards were surveyed regarding the need for HIV services. Then in the summer, focus groups of people living with HIV/ADS in New York were conducted to contribute to a national project to gather input regarding reauthorization of the CARE Act, set to occur in 2005.

In preparation for developing the EMA's recommendations for service priorities and resource allocations for FY 2005, the Planning Council's PLWA/HIV Advisory Group surveyed consumer advisory boards from 134 service provider organizations. Participants were asked to rank Title I service categories that promote access to and maintenance in HIV-related primary care and current gaps in HIV-related services (212:5). Qualitative data was also collected. Finally, consumers on the boards were queried on the level of satisfaction with the Title I services they receive (212:7). A total of 72 responses representing 62 agencies and their satellite sites were received (212:4).

The top ranked Title I service categories promoting access to and maintenance in care are:

1. Case management
2. Access to care and early intervention
3. ADAP
4. Food/nutrition
5. Transportation
6. Housing

The top current gaps in HIV-related services are:

1. Housing
2. Legal services
3. Food/nutrition
4. Home care and supportive services
5. Transportation

Nearly all survey participants (90%) reported satisfaction with the Title I services they receive:

- 45% reported being "very satisfied"
- 45% reported being "satisfied"

The National Association of People with AIDS (NAPWA) sponsored focus groups in 10 Title I EMAs across the country to develop data on CARE Act consumer service needs, satisfaction, and planning body involvement. The data is needed for assessment of the CARE Act Amendments of 2000, which is to be reauthorized by Congress in 2005. In New York, a total of five focus groups were held: four in English and one in Spanish. A total of 46 people living with HIV/AIDS participated in the New York focus groups. The participants collectively reflected the demographics of the AIDS epidemic in New York.

The English-speaking focus groups cited the following as service needs for CARE Act reauthorization (218:5):

- Full funding for ADAP;
- Increased access to housing;
- Assistance with workforce re-entry;
- Expanded mental health services; and
- Expanded dental services.

The Spanish-speaking focus group cited the following similar list of service needs, but with a few differences of note (219:3):

- Full funding for ADAP;
- Increased access to housing;
- Expanded support group services;
- Greater outreach;
- Dental services; and
- Enhanced translation and cultural competency training.

Some focus group participants reported on the limited availability of certain specific service categories and on dissatisfaction with service access barriers such as waiting lists for key unmet needs such as housing.

Treatment Education and Adherence Programs Targeting Minority Communities

In April 2004, evaluators of the New York EMA's Minority AIDS Initiative reported on results of Title I funded treatment education and adherence programs targeting minority populations (213). In New York City, 12 community-based agencies have received funding through the Minority AIDS Initiative to provide treatment education and intake assessments, treatment education workshops, counseling, and follow up encounters. A total of 2,893 individuals have been served.

Information from participants in treatment education and adherence programs indicate program effectiveness, in particular:

- 57% of participants reported improved adherence to treatment;
- 56% reported improved CD4 counts; and
- 64% reported improved viral loads.

Participant experiences are collated to certain key outcomes, including:

- Participants who adhered to their prescribed treatment improved more than those who did not;
- Participants with initially lower CD4 counts improved more than those with higher counts;
- Participants with initially higher viral loads improved more than those with lower loads;
- Participants who improved adherence to their prescribed treatment improved more than those who did not;
- Participants who had been prescribed medications at the time they entered the programs improved more than those who did not; and
- Participants who stayed in their programs continued to benefit.

Finally, the evaluators offer a number of findings:

- Better adherence leads to better health;
- Those with the poorest CD4 counts benefit the most;
- Those who benefit the most are those who are initially in the poorest health;
- If programs are able to increase adherence to treatment, the health of the participants will improve; and
- Participants benefit quickly and continue to benefit if they remain in the program.

CHAIN Service Gaps

The Needs Assessment Update presented data from several earlier versions of the CHAIN Service Gap study. The findings presented below represent the latest version of this data, published in July 2004 (217:4-7). The gap study focuses on two topics: service gaps (examining six service categories) and service utilization (examining reported service use patterns for individuals and groups in the CHAIN cohort).

In order to establish a service gap, the researchers first identified CHAIN participants with a specific need, and then examined how many with that need were not receiving the corresponding service. That proportion, of “not receiving services” divided by all those with a need, represents the service gap. It was assumed that all CHAIN participants needed comprehensive medical care and patient/provider communications. Other high need services included 75% with a need for comprehensive case management, 71% with a need for treatment adherence assistance, and 71% with a need for alcohol and drug treatment services.

Among people with a specific need, those areas with the greatest proportion of people not reporting corresponding service were transportation services (77%), alcohol or drug treatment (70%), and professional mental health services (63%).

An absolute ranking of service gaps (amongst the entire HIV/AIDS population, not just those with a need) can be calculated by multiplying the service gap proportion by the proportion of those with need. For example, looking at alcohol or drug treatment, 71% of CHAIN participants had a need for alcohol and other drug (AOD)

treatment, and 70% of those individuals reported a service gap in that they did not receive treatment. In order to understand how this impacts the entire CHAIN cohort, 0.71 is multiplied by 0.70, giving 0.50. This means that half of the entire cohort had a service gap for AOD treatment.

Using this method, the top five service gaps for the CHAIN cohort were:

- Alcohol or drug treatment (50% of the entire cohort);
- Patient/provider communications (38% of the entire cohort);
- Comprehensive case management (30% of the entire cohort);
- Comprehensive medical care (24% of the entire cohort); and
- Professional mental health services (23% of the entire cohort).

Special attention was given to case management service gaps, since case management provides an integrative function and is considered to be central to any HIV care system. In looking at subgroup differences in terms of access to case management services, the statistically significant difference existed among women, who were more likely to experience a service gap than men.

Individuals who had a comprehensive case management service gap were also more likely to have significant service gaps in comprehensive medical care, supportive mental health services, financial and permanent housing, and transportation. This suggests that if the comprehensive service gap of case management services were addressed, some of these other service gaps might also diminish.

Other key findings include:

- Individuals with very low mental health scores (those with clinically relevant mental symptoms) were more likely to experience comprehensive medical care service gaps and financial housing gaps;
- Individuals with less than a high school education or with annual household incomes below \$10,000 were more likely to experience medical communication gaps and financial housing service gaps;
- Younger individuals (20-30 years old) were more likely to experience permanent housing service gaps; and
- Women were more likely than men to experience treatment adherence and comprehensive case management service gaps and men were more likely than women to experience professional mental health service gaps.

Regarding service utilization, overall, the three highest areas of service utilization were primary medical care (97%), case management (72%) and dental care (71%). Mental health services (57%), housing (31%), and substance abuse services (24%) were used moderately. Relatively few people in the cohort (2-7%) reported food, home health care, legal services, and transportation services.

There were only two statistically significant subgroup differences in service utilization: white respondents were more likely than Black or Latino respondents to

report using substance use services, and middle-aged respondents (35-49 years old) were more likely than younger or older individuals to report using mental health services.

CHAIN Treatment Success Data

A July 2004 CHAIN study (215:2&3) examined the relationship between social, behavioral and service factors and treatment success. For this study, treatment success was defined as a self-reported viral load below 400 c/ml among individuals receiving combination therapy. Key findings included:

- 63% of combination-therapy-experienced CHAIN participants reported treatment success (viral loads <400) at the time of their last interview. The success rate increased to 70% among cohort members currently on HAART at the time of last interview.
- Currently being on HAART and being completely adherent to HAART were the most important factors associated with treatment success.
- “Drug holidays” – Or treatment interruption, in which individuals purposefully interrupted their treatment regimens – were associated with a significant reduction in treatment success.
- There was minimal and uncertain association between treatment success and other independent factors. The most robust findings indicated that unstable housing and younger age were associated with reduced treatment success.
- The quality of medical care, but not the use of ancillary services, was associated with treatment success. Reports of barriers that impeded timely access to needed medical services lowered the likelihood of treatment success. Use of case management services, drug treatment, mental health, and housing were all unrelated to treatment success. It should be noted that the large number of missing viral loads introduced a degree of uncertainty about the true nature of social influences on treatment outcomes.

A related study (221:23-24) examined the accuracy of self-reported viral load data by CHAIN participants. The researchers found generally reliable self-reporting by respondents regarding demographic characteristics, CD4 and viral load counts, and listings of HIV medications. Somewhat less accurate self-reporting was found relative to medical conditions.

HIV/AIDS Population Over 50 Years of Age

Ivana Williams, Senior Program Management Officer, HRSA/HAB Division of Science and Policy, Policy and Program Development Branch, reported the following issues and challenges related to the 50+ HIV/AIDS population (223:23):

- Denial of risk among seniors;
- Lack of education about HIV;
- HIV infection not considered a possibility by clinicians;
- Services do not target seniors;
- Seniors are unlikely to share an HIV diagnosis with family or others;
- Co-morbidities and other age-related illnesses affect AIDS therapies;

- Infected seniors develop AIDS more rapidly and have higher mortality rates than younger people; and
- Age discrimination and stigma.

The following recommendations were made for addressing the needs of the 50+ population (223:24-25):

- Design and implement age specific and culturally appropriate prevention and treatment programs;
- Strategies must consider three disparate groups: 1) infected and high risk seniors; 2) seniors living with infected children or other family members, and 3) seniors who are family caregivers for someone with HIV/AIDS; and
- Effective strategies for dealing with the 50+ population should include:
 - ✓ Dispel the stigma of HIV/AIDS;
 - ✓ Provide targeted and effective support services; and
 - ✓ Include age appropriate prevention and treatment services.

Title I HIV Quality Management Program

In 2001, the New York State Department of Health AIDS Institute was awarded a contract through the HIV Health and Human Services Planning Council of New York City to measure the quality of health and supportive services provided under Title I.

To date, reviews have been conducted in the following areas:

- Adult Day Treatment
- Tuberculosis (TB) Directly Observed Therapy/Directly Observed Preventive Therapy (DOT/DOPT)
- Home Care
- Treatment Education and Adherence
- Mental Health
- Case Management

Aggregate data for selected indicators are included in *Section 6*. Indicators were developed using nominal group technique process involving the appropriate Planning Council Workgroups, Title I-funded providers, and other expert groups. Indicators can be reviewed at the HIV Clinical Resource website located at www.hivguidelines.org.

To date, most of the data that have been collected through the HIV Quality Management Program have been related to process measures. (Refer to *Appendix: Title I Quality Management Program, Needs Assessment Update Summary*). However, in response to shifting priorities, and desire for more outcome-related data, additional outcome indicators will be added to the existing set of indicators for collection during the next cycle of reviews. Data for 2004 will therefore include a greater proportion of outcome related data; in order to complement the process of related data already being collected.

It continues to be an expectation of Title I funded providers that quality improvement activities be initiated that are based on data collected. In order to facilitate this process, the AIDS Institute has created three quality improvement networks to date in the areas of adult day treatment, mental health, and case management. In addition, HIVQUAL consultants work with numerous primary care providers in the Title I EMA. Providers have made significant improvements in certain aspects of care, particularly in care coordination. Additional quality improvement networks will be initiated in the coming months as providers receive performance data upon which they can base quality improvement efforts.

Summary findings from the areas examined by HIVQUAL follow:

Primary Care Data Collected by an External Chart Review (2001–2002): Aggregate scores remained fairly constant between 2001 and 2002 for most indicators including appropriate management of ARV therapy, TB screening, pelvic examinations, viral load monitoring, and adherence assessments. Data for 2003 are expected to be available in early 2005. Scores for facilities reporting through HIVQUAL are reported separately.

Primary Care Data Collected by Agencies (HIVQUAL) (2001–2002): Aggregate scores remained fairly constant between 2001 and 2002, in most cases largely mirroring scores obtained through external chart reviews conducted by the external reviewers.

Adult Day Treatment Reviews (2002): Facilities performed well in many areas in their first year of quality of care reviews. Areas of strength included comprehensive medical exams within 30 days, initial assessments in subspecialty areas, and coordination of health-related services. Facilities need improvement in other areas including subspecialty reassessments, timely development of a comprehensive care plan, patient participation in care plan development, documentation of laboratory results, adherence assessments, coordination and/or provision of annual exams, and communication between the adult day health care program and the primary care provider. Communication and coordination between these two provider types has become an area of focus for the adult day treatment quality improvement network, and scores are expected to increase.

Treatment Education/Adherence Reviews (2001-2003): In almost all areas, treatment education/adherence performance improved from 2001 to 2002, and similarly from 2002 to 2003. This was true both for providers being reviewed for the first time in 2002 as well as for providers that were initially reviewed in 2001. Improvement was noted in the areas of quarterly treatment education, assessment of adherence, assessments of barriers to adherence, discussion of ARV side effects and their management, and assessment of whether patients were attending appointments with their primary care provider on a routine basis.

Mental Health Reviews (2002 – 2003): Scores in most areas for most facilities were high in 2003, including cognitive assessments, multi-axis diagnosis, and annual psychosocial assessments. In addition, most facilities showed improvements in these areas from 2002 to 2003 reviews. Assessment for psychiatric medication side effects, however, dropped from 52% to 43%. There continues to be discussion about whether assessments for side effects should routinely occur on a monthly basis or whether quarterly assessments are sufficient. Until consensus is reached, scores will be reported for both time periods. Improving coordination and communication with the primary care provider has been a goal of the Mental Health Quality Improvement Network. Dramatic results have been achieved. Many providers have reported benefiting from the peer learning approach, utilizing both tools and strategies recommended by other mental health provider organizations. Data for calendar year 2004 will be collected in January and February 2005 and will be available by the summer.

Case Management (2003): Facilities scored quite high in most areas, including in the areas of comprehensive assessment within 30 days of admission and development of a service plan within 45 days. The area of greatest weakness, similar to other program areas, is in coordination of care (56%). This is an area of focus for the Case Management Quality Improvement Network.

Section VI. Data Sources

This section lists all the sources used for developing this Addendum through November 15, 2004. The Office of AIDS Policy Coordination, the New York City Department of Health and Mental Hygiene, CHAIN, the New York State AIDS Institute and Pagnoni & Associates provided these documents.

Every document was given a unique code number beginning with #211 (the Needs Assessment Update having listed through #210). All documents were studied for their relevance to needs assessment and the planning process.

211. *New York City Community Health Profiles*, New York City Department of Health and Mental Hygiene, 2003.
212. *New York City Ryan White CARE Act Title I Consumer Advisory Group Survey Report*, New York City Department of Health and Mental Hygiene, May 2004.
213. *Impact of the Minority AIDS Initiative on Participants in Treatment Education and Adherence Programs: Summary*, Laurence A. Pagnoni Associates and Philliber Research Associates, April 2004.
214. *Semi-Annual Report: Pediatric & Adolescent HIV/AIDS Surveillance Update*, New York City HIV Epidemiology Program, June 2004.
215. *HIV Epidemiology Program, 3rd Quarter Report*, New York City Department of Health and Mental Hygiene, July 2004.
216. *Client Attributes and Services Intervention Correlates of Self Reported Viral I Load Levels*, CHAIN Report 2003-4, July 1, 2004.
217. *Strategic Service Gaps and Utilization in the Continuum of Care in New York City*, CHAIN Report 2004-1, Revised July 14, 2004.
218. *New York EMA Consumer Input Report: Focus Groups on CARE Act Reauthorization*, August 2004.
219. *New York EMA Consumer Input Report: Spanish Speaking Focus Groups on CARE Act Reauthorization*, August 2004.
220. *Baseline Summary of New York City II Cohort: Demographics and Other Characteristics, Health Status and Health Services Use, Needs Assessment (draft)*, CHAIN Report 2004-3, September 15, 2004.
221. *Pilot Study*. CHAIN Technical Report 2004-6, September 15, 2004.

222. *Planning Council Orientation Presentation, Understanding the Epidemiology of AIDS in New York City*, New York City Department of Health and Mental Hygiene, HIV Epidemiology Program, October 2004.
- 223 The Invisible Population in the HIV/AIDS Epidemic – Persons 50 and Older, Ivana R. Williams, HRSA/HAB, October 2, 2004.
224. The Epidemiology of HIV/AIDS in Persons Age 50+, Susan W. Forlenza, MD, New York City Department of Health and Mental Hygiene.

Appendix: Title I HIV Quality Management Program, Needs Assessment Update Summary

The Title I HIV Quality Management Program conducted initial reviews in 2001. To date, reviews have been conducted in the following areas:

- Adult Day Treatment
- TB DOT/DOPT
- Home Care
- Treatment Education and Adherence
- Mental Health
- Case Management

Aggregate data for selected indicators are listed on the following pages. Indicators can be reviewed at the HIV Clinical Resource website located at www.hivguidelines.org.

Mental Health (2002–2003)

Background:

Indicators were developed through a nominal group technique process involving the AIDS Institute Mental Health Clinical Guidelines Committee, the Title I Mental Health Workgroup, and Title I-funded mental health providers.

Sample:

A total of 903 patient records were reviewed at 21 facilities for calendar year 2002.

A total of 675 patient records were reviewed at 22 facilities for calendar year 2003.

Selected Results:

Annual Cognitive Assessment: Most facilities routinely assess cognitive function. In 2002, 98% of all patients were assessed for at least one component of cognitive function. In 2003, this figure rose to 99%. The language component of the cognitive assessment remains the component most infrequently assessed (20% in both 2002 and 2003).

Annual Multi-axis Diagnosis: Most facilities routinely assess for this. All five axes were assessed at a rate of 83% in 2002 and 92% in 2003.

Psychiatric Medication Side Effects (Monthly): Aggregate scores for this indicator dropped from 52% to 43% from 2002 to 2003.

Annual Psychosocial Assessment: Facilities demonstrated a significant improvement in this area, increasing from 76% of all components of the assessment performed in 2002 to 93% of all assessments performed in 2003.

Coordination of Care with Client's Primary Care Provider (quarterly): Scores more than doubled from 2002 (25%) to 2003 (54%). This has been an area of focus for the quality improvement network.

Summary of Findings:

Scores in most areas for most facilities were high. Assessment for psychiatric medication side effects, however, dropped from 52% to 43%. There continues to be discussion among the group about whether assessments for side effects should routinely occur on a monthly basis or whether quarterly is sufficient. Until consensus is reached, we will report scores for both time periods.

Improving coordination and communication with the primary care provider has been a goal of the Mental Health Quality Improvement Network. Dramatic results have been achieved to date. Many providers have reported benefiting from the peer learning approach, utilizing both tools and strategies recommended by other mental health provider organizations.

Data for calendar year 2004 will be collected in January and February 2005 and will be available by summer of that year.

Adult Day Treatment (2002)

Background:

Indicators were developed through a nominal group technique process involving program directors and medical directors from the Adult Day Treatment Programs.

Sample:

A total of 183 patient records were reviewed at 12 facilities for calendar year 2002.

No reviews were conducted for 2003. Facilities will be submitting self-collected data for 2004 using HIVQUAL software. Data will be validated by IPRO.

Selected Results:

Comprehensive Medical Exam Performed within 30 Days of Admission: 90% of all patients had at least one component of the exam performed within 30 days of admission. Scores ranged from 34% (cholesterol/triglycerides for patients on ARV) to 90% (medical history) for selected components.

Initial Assessments within 30 Days of Admission:

- Substance use – 86%
- Nutrition – 84% (components of assessment range from 33% - 84%)
- Psychosocial/mental health – 91% (components range from 79% to 91%)
- Nursing – 89% (components range from 78% to 88%)

Comprehensive Care Plan within 30 Days of Admission: 66%

Quarterly laboratory monitoring:

- CD4 – 60%
- Viral load – 59%

Adherence Measured Monthly for Patients on ARV: 69%

Annual Examinations:

- Oral health – 29%
- Pelvic – 45%

Coordination of Health-related Services (receipt within 4 weeks of identified need):

- Substance use – 93%
- Mental health treatment – 95%

Coordination of Care with Primary Care Provider (quarterly):

- Communication from ADHC to primary care provider – 15%
- Communication from primary care provider to ADHC – 51%

Summary of findings:

Facilities performed well in many areas in their first year of quality of care reviews. Areas of strength included comprehensive medical exams within 30 days, initial assessments in subspecialty areas, and coordination of health-related services. Facilities could use improvement in other areas including subspecialty reassessments, timely development of a comprehensive care plan, patient participation, documentation of laboratory results, adherence assessments, coordination and/or provision of annual exams, and communication between the adult day health care program and the primary care provider. Communication and coordination between the two groups has become an area of focus for the adult day treatment quality improvement network, and scores are expected to increase.

Treatment Education/Adherence (2001–2003)

Background:

Indicators were developed through a nominal group technique process involving Title I-funded treatment education and adherence providers.

Sample:

A total of 445 patient records were reviewed at 9 facilities for calendar year 2001.

A total of 1068 patient records were reviewed at 23 facilities for calendar year 2002.

A total of 946 patient records were reviewed at 23 facilities for calendar year 2003.

Selected Results:

Treatment Education (quarterly): 2001 = 56%; 2002 = 64%; 2003 = 75%

Adherence assessed and described quantitatively (every 4 months): 2001 = 48%; 2002 = 55%; 2003 = 64%

Treatment Adherence Barrier Assessment:

- Every 3 months
 - Mental illness: 2001 = 63%; 2002 = 59%; 2003 = 64%
 - Medication access: 2002 = 34%; 2002 = 71%; 2003 = 82%
 - Primary care access: 2002 = 70%; 2002 = 74%; 2003 = 83%
- Every 6 months
 - Lack of social support: 2001 = 81%; 2002 = 69%; 2003 = 73%
 - Substance use: 2001 = 53%; 2002 = 65%; 2003 = 71%
 - Inadequate housing: 54%; 2002 = 68%; 2003 = 70%

Discussion of ARV Side Effects and Management (every 6 months):

2001= 65%; 2002 = 74%; 2003 = 74%

Assessment of whether seeing PCP (quarterly): 2001 = 69%; 2002 = 67%; 2003 = 75%

Summary of Findings:

In almost all areas, Treatment Education/Adherence providers improved from 2001 to 2002, and similarly from 2002 to 2003. This was true both for providers being reviewed for the first time in 2002 as well as for providers that were initially reviewed in 2001.

HIV Home Health Care (2001–2002)

Background:

Indicators were developed through a nominal group technique process involving Title I-funded HIV Home Care Providers.

Sample:

A total of 346 patient records were reviewed at 5 facilities for calendar year 2001.

A total of 306 patient records were reviewed at 4 facilities for calendar year 2002.

Selected Results:

HIV-related education provided monthly: 2001 = 41%; 2002 = 79%

Monthly Biopsychosocial Assessment:

- Physical exam: 2001 = 84%; 2002 = 74%
- Mental status: 2001 = 82%; 2002 = 77%
- Psychological: 2001 = 83%; 2002 = 73%
- Nutritional: 2001 = 83%; 2002 = 66%

Assessment for Needs:

- Durable medical equipment: 2001 = 85%; 2002 = 81%
- Therapies (physical, speech, etc.): 2001 = 82%; 2002 = 78%
- Home Health Aide: 2001 = 89%; 2002 = 83%

Treatment Adherence every 4 months: 2001 = 32%; 2002 = 33%

Assessment for Pain: 2001 = 78%; 2002 = 91%

Summary of Findings:

Because of the small number of facilities reviewed, the data above obscure the fact that two of the providers reviewed improved in most areas from Year 1 to Year 2, while the other two providers declined in performance over the two years. While data for Year 3 (2003) have been collected, analysis is not yet complete and data are therefore not yet ready for distribution.

Tuberculosis Directly Observed Therapy/ Directly Observed Preventive Therapy (2001–2002)

Background:

Indicators were developed through a nominal group technique process involving Title I-funded TB DOT/DOPT providers with additional recommendations provided by physicians managing HIV patients with TB at the respective facilities.

Sample:

A total of 94 patient records were reviewed at 4 facilities for calendar year 2001.

A total of 105 patient records were reviewed at 4 facilities for calendar year 2002.

Selected Results:

DOPT initiated for new patients within 48 hours of enrollment: 2001 = 98%; 2002 = 81%

Adherence to DOT/DOPT appointments measured monthly: 2001 = 85%; 2002 = 79%

Assessment of monthly visit to PCP: 2001 = 54%; 2002 = 46%

Attempt to contact client within 24 hours of missed visit: 2001 = 76%; 2002 = 79%

Summary of Findings:

The number of DOT/DOPT patients at most facilities reviewed has been quite small with the exception of one program.

Scores from 2001 to 2002 have declined in most areas. It is unclear what the reason behind this is. To date, there has been only limited application of quality improvement methodology, primarily because of the small number of facilities involved. In fact, since the last set of reviews, one program is no longer operational because of small caseload.

Case Management (2003)

Background:

Indicators were developed through a nominal group technique process involving the Title I Social Services Workgroup and Title I-funded case management providers.

Sample:

A total of 725 client records were reviewed at 36 facilities for calendar year 2003.

Selected Results:

Comprehensive Case Management Assessment Performed within 30 Days of Admission: 92% of all patients had at least one component of the assessment performed within 30 days of admission. Scores ranged from 66% (food and nutrition) to 91% (housing status) for selected components of the assessment.

Goals identified in Service Plan are Followed Up on Every 120 Days until Achieved: 56%

Referrals identified in Service Plan are Followed Up on Every 120 Days until Achieved: 58%

Service Plan Developed within 45 Days of Initial Contact: 83%

Service Plan Developed with Client Participation: 79%

Coordination of services with other health service provider (quarterly): 50%

Summary of Findings:

Facilities scored quite high in most areas, particularly considering this was a first year review. The area of greatest weakness, similar to other program areas, is in coordination of care (56%). This is an area of focus for the Case Management Quality Improvement Network.

HIV Primary Care (2001–2002)

Co-funded through Ryan White Title II

Background:

Indicators were developed through a nominal group/Delphi technique process involving the HIV Quality of Care Advisory Committee. Data presented below are for facilities located within the Title I EMA.

Sample:

A total of 3,079 patient records were reviewed at 58 facilities in the Title I EMA for primary care reviews covering most of 2001.

A total of 3,655 patient records were reviewed at 60 facilities in the Title I EMA for primary care reviews covering most of 2002.

Eligibility for reviews is a minimum of two visits during the year with at least one in the previous six months. Scores from facilities reporting through HIVQUAL are not included in the scores below.

Selected Results:

Appropriate Management of ARV Therapy (every 4 months): 2001 = 77%; 2002 = 73%

PPD Placed and Read (annually): 2001 = 72%; 2002 = 70%

Pelvic Examination (annually): 2001 = 77%; 2002 = 73%

Mental Health Assessment (annually): No review in 2001; 2002 = 21%

Viral Load Monitoring (every four months): 2001 = 63%; 2002 = 65%

Adherence Assessed and Quantified (quarterly, for patients with detectable viral load):

2001 = 85%; 2002 = 87%

Summary of Findings:

Aggregate scores remained fairly constant between 2001 and 2002. Data for 2003 are expected to be ready in early 2005. Scores for facilities reporting through HIVQUAL are not included in aggregate data estimates as mentioned above.

HIV Primary Care (2001–2002)
HIVQUAL Facilities (self-reported data)
Co-funded through Ryan White Title III

Background:

Indicators were developed through a nominal group/Delphi technique process involving the HIV Quality of Care Advisory Committee. Data presented below are for facilities located within the Title I EMA.

Sample:

A total of 1,526 patient records were reviewed at 32 facilities in the Title I EMA for primary care reviews for calendar year 2001.

A total of 1,752 patient records were reviewed at 36 facilities in the Title I EMA for primary care reviews for calendar year 2002.

Eligibility for reviews is a minimum of two visits during the year with at least one in the previous six months. Scores from facilities reviewed by IPRO are not included in the scores below.

Selected Results:

Appropriate Management of ARV Therapy (for entire year): 2001 = 64%; 2002 = 68%

PPD Placed and Read (annually): 2001 = 69%; 2002 = 63%

Pelvic Examination (annually): 2001 = 76%; 2002 = 70%

Mental Health Assessment (annually): 2001 = 50%; 2002 = 54%

Viral Load Monitoring (every 4 months): 2001 = 49%; 2002 = 53%

Summary of Findings:

Aggregate scores remained fairly constant between 2001 and 2002.

HIV Outcome Measures

To date, most of the data that have been collected through the HIV Quality Management Program have been related to process measures. However, in response to shifting priorities, and desire for more outcome-related data, additional outcome indicators will be added to the existing set of indicators for collection during the next cycle of reviews. Data for 2004 will therefore include a greater proportion of outcome related data; in order to complement the process related data already being collected.

Quality Improvement Networks

It continues to be an expectation of Title I funded providers that quality improvement activities be initiated that are based on data collected. In order to facilitate this process, the AIDS Institute has created three quality improvement networks to date in the areas of adult day treatment, mental health, and case management. In addition, HIVQUAL consultants work with numerous primary care providers in the Title I EMA. Providers have made significant improvements in certain aspects of care, particularly in care coordination. Additional quality improvement networks will be initiated in the coming months as providers receive performance data upon which they can base quality improvement efforts.