



*CHAIN Presentation*

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Service Gaps &  
Strategic Plan  
Progress Indicators

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**SUMMARY FINDINGS**

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

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The data presented in these summary tables are drawn from 622 respondents from NYC CHAIN Cohort II, which was recruited from 2002-2003, and also include data from 652 participants from the original NYC CHAIN Cohort I, which recruited participants first in 1994-1995, and then again in 1998. Participants are drawn from a multi-stage random sample in which first a random selection of HIV medical and social service agencies are identified, and then a random selection of clients at those agencies are recruited. The CHAIN cohorts thus represent a reasonably representative “slice” of HIV-positive adults in the public system of care in New York City. These preliminary summary tables are drawn from two longer reports that are presently in production – *CHAIN Report 2004\_1 – Service Gaps*, and *CHAIN Report 2004\_2 – Strategic Plan Progress Indicators: New Cohort Update*.

Because these findings represent preliminary data from the two larger CHAIN reports, the final versions of these reports may differ slightly from the current presentation. There will be a slightly larger number of respondents used in the final analyses, and some of the measures and progress indicators will be modified in response to suggestions and comments elicited from Work Group members and participants at the Planning Council's Data Day 2 and Data Day 3 in 2003-2004.

All of the measures of needs, service gaps, and progress indicators will be analyzed by subgroups and subpopulations, including: gender, race/ethnicity, age group, borough, HIV risk behavior, and year of diagnosis.

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**Table 1. Measuring Needs & Service Gaps – Definitions**

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

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

**Table 2. Measuring Needs & Service Gaps – Findings**

| Service                        | NEED             |   | SERVICE GAP  |  |
|--------------------------------|------------------|---|--|--|
|                                | Number with Need | Proportion of Full Cohort (n=622) with Need | Among those with Need, the Number with a Service Gap | Proportion of those with Need Experiencing Service Gap |
| <b>HEALTH</b>                  |                  |   |  |  |
| Comprehensive medical care     | 622              | 100%  | 148  | 24%  |
| Patient/Provider communication | 622              | 100%  | 235  | 38%  |
| Treatment adherence            | 440              | 71%   | 82   | 19%  |
| Antiretroviral therapy         | 127              | 20%   | 35   | 28%  |
| <b>CASE MANAGEMENT</b>         |                  |   |  |  |
| CM: Social work model          | 466              | 75%   | 186  | 40%  |
| CM: Counseling model           | 348              | 56%   | 134  | 39%  |
| <b>HOUSING</b>                 |                  |   |  |  |
| Financial Housing Services     | 156              | 25%   | 50   | 32%  |
| Permanent Housing Services     | 126              | 20%   | 37   | 29%  |
| <b>MENTAL HEALTH</b>           |                  |   |  |  |
| Professional Mental Health     | 233              | 37%   | 147  | 63%  |
| Supportive Mental Health       | 85               | 14%   | 29   | 34%  |
| <b>ALCOHOL OR DRUGS</b>        |                  |   |  |  |
| AOD                            | 440              | 71%   | 309  | 70%  |
| <b>TRANSPORTATION</b>          |                  |   |  |  |
| Transportation Services        | 132              | 21%   | 101  | 77%  |

**Table 2. Measuring Needs & Service Gaps – Subgroup Differences\***

| Service                        | NEED  | SERVICE GAP  |
|--------------------------------|---|--|
|                                | Groups significantly more likely to experience a need | Groups significantly more likely to experience a service gap |
| <b>HEALTH</b>                  |   |  |
| Comprehensive medical care     |   | – Blacks   |
| Patient/Provider communication |   | – Problem drug user<br>– MSM who were problem drug users     |
| Treatment adherence            | – Heterosexual HIV risk                               | – Women  |
| Antiretroviral therapy         |   |  |
| <b>CASE MANAGEMENT</b>         |   |  |
| CM: Social work model          | – Whites<br>– Latinos                                 | – Women  |
| CM: Counseling model           | – MSM who were problem drug users                     |  |
| <b>HOUSING</b>                 |   |  |
| Financial Housing Services     |   |  |
| Permanent Housing Services     |   |  |
| <b>MENTAL HEALTH</b>           |   |  |
| Professional Mental Health     | – Whites<br>– Latinos<br>– Residents of Queens        | – Men  |
| Supportive Mental Health       | – Residents of Bronx, Bklyn, Manhhtn                  |  |
| <b>ALCOHOL OR DRUGS</b>        |   |  |
| AOD                            |   | – Blacks<br>– Latinos  |
| <b>TRANSPORTATION</b>          |   |  |
| Transportation Services        | – Women<br>– Heterosexual HIV risk                    |  |

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

**Strategic Plan: HEALTH Work Group Objectives**  
CHAIN Performance Measures, last updated Jan. 28, 2004

| <b>Obj #</b> | <b>Objective</b>   | <b>Progress Indicator</b>  | <b>% of Baseline CHAIN cohort with Positive Indicator (1998-2001), n=652</b> | <b>% of New CHAIN cohort with Positive Indicator (2002-2003), n=562</b> | <b>Groups in New CHAIN cohort with statistically lower progress</b> |
|--------------|--|--|--|---|---|
| 1A-1         | PLWHA will have improved survival and health outcomes                        | Self-reported health status score is at or above national average for "good health"                            | <b>48%</b>   | <b>51%</b>  | 1. Whites<br>2. Latinos<br>3. Problem drug users<br>4. CD4<500      |
| 1A-2         | PLWHA will have improved survival and health outcomes                        | Self-reported CD4 count is greater than 500 cells/mm <sup>3</sup>  | <b>34%</b>   | <b>34%</b>  |   |
| 1B           | Persons who receive health services will adhere to treatment                 | Self-reported adherence to HIV medications   | <b>67%</b>   | <b>72%</b>  | 1. Women<br>2. Blacks<br>3. Whites                                  |
| 2A           | PLWHA will remain connected to services once in the care continuum           | Reported same primary doctor as of last interview or within past year  | <b>69%</b>   | <b>76%*</b>   | 1. Men<br>2. MSM  |
| 3A-1         | PLWHA in care will receive services that meet or exceed AI quality standards | Reported medical care that met minimal preferred practice guidelines   | <b>71%</b>   | <b>74%</b>  |   |
| 3A-2         | PLWHA in care will receive services that meet or exceed AI quality standards | Primary medical provider is available for well-visits, available for health advice, and available 24 hours/day | <b>75%</b>   | <b>77%</b>  | 1. Blacks   |
| 3B           | PLWHA report health-related quality of life as good or better                | Self-reported health is "good," "very good," or "excellent"  | <b>66%</b>   | <b>65%</b>  | 1. Problem drug users<br>2. CD4 below 200                           |

*\* Percentage reported by new cohort is statistically significantly different than the older cohort*

**Strategic Plan: HOUSING Work Group Objectives**  
 CHAIN Performance Measures, last updated Jan. 28, 2004

| <b>Obj #</b> | <b>Objective</b>  | <b>Progress Indicator</b>  | <b>% of Original CHAIN cohort with Positive Indicator (1998-2001), n=652</b> | <b>% of New CHAIN cohort with Positive Indicator (2002-2003), n=562</b> | <b>Groups in New CHAIN cohort with statistically lower progress</b> |
|--------------|---|--|--|---|---|
| 1A-1         | Transitional housing will be available to PLWHA who need it                     | Percent who reported being unstably housed, who had any episode of living on street, in shelter, SRO, or doubled-up with friend or relative in past 6 months | <b>18%</b>   | <b>28%*</b>   | 1. Men  |
| 1A-2         | Transitional housing will be available to PLWHA who need it                     | Percent who reported being homeless  | <b>10%</b>   | <b>18%*</b>   |   |
| 2A           | Housing placement assistance services will be available for PLWHA who need them | Among those who reported any unstable housing, percent who received housing subsidy, lived in specialized AIDS housing, or received housing services         | <b>33%</b>   | <b>47%*</b>   |   |

*\* Percentage reported by new cohort is statistically significantly different than the older cohort*

**Strategic Plan: AOD Work Group Objectives**  
 CHAIN Performance Measures, last updated Jan. 28, 2004

| <b>Obj #</b> | <b>Objective</b>  | <b>Progress Indicator</b>   | <b>% of Original CHAIN cohort with Positive Indicator (1998-2001), n=652</b> | <b>% of New CHAIN cohort with Positive Indicator (2002-2003), n=562</b> | <b>Groups in New CHAIN cohort with statistically lower progress</b> |
|--------------|---|---|--|---|---|
| 1A           | Health care/mental health and other providers will understand AOD culture and provide culturally appropriate and sensitive treatment to AOD users | Among those who reported current or past drug use, the percent who delayed or did not get medical or social services because of barriers experienced  | <b>18%</b>   | <b>17%</b>  | 1.Heterosexual HIV risk   |
| 1B           | Health care, mental health, and other services will be more available and accessible to AOD users   | Among those who reported current or past drug use, and who had an objective need for mental health services (a low mental health score on a standardized scale), the percent who reported they received professional or supportive mental health services | <b>50%</b>   | <b>60%</b>  |   |

*\* Percentage reported by new cohort is statistically significantly different than the older cohort*

**Strategic Plan: INFRASTRUCTURE Work Group Objectives**  
 CHAIN Performance Measures, last updated Jan. 28, 2004

| <b>Obj #</b> | <b>Objective</b>  | <b>Progress Indicator</b>  | <b>% of Original CHAIN cohort with Positive Indicator (1998-2001), n=652</b> | <b>% of New CHAIN cohort with Positive Indicator (2002-2003), n=562</b> | <b>Groups in New CHAIN cohort with statistically lower progress</b> |
|--------------|---|--|--|---|---|
| 1A           | Appropriate information will be available on the type and location of services and on options for choosing services that best meet the needs of PLWHA | Percent who reported they delayed or did not get medical or social services because they did not know where to go for services | 11%  | 11%   | 1. Women  |

*\* Percentage reported by new cohort is statistically significantly different than the older cohort*

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

CHAIN Performance Measures, last updated Jan. 28, 2004

| <b>Obj #</b> | <b>Objective</b>   | <b>Progress Indicator</b>  | <b>% of Original CHAIN cohort with Positive Indicator (1998-2001), n=652</b> | <b>% of New CHAIN cohort with Positive Indicator (2002-2003), n=562</b> | <b>Groups in New CHAIN cohort with statistically lower progress</b> |
|--------------|--|--|--|---|---|
| 1B           | PLWHA will have access to culturally competent and linguistically appropriate social services                      | Percent who delayed or did not get medical or social services because staff did not speak their language; were not competent to deal with problem; were not polite, respectful or sensitive; did not understand their problem; or did not listen to their problem or needs | <b>15%</b>   | <b>13%</b>  | 1. Whites   |
| 1C           | PLWHA will have access to necessary transportation services  | Among those who reported needing help with transportation, or who said it was a barrier to receiving, percent who received transportation services   | <b>45%</b>   | <b>38%</b>  |   |
| 1D           | PLWHA will have access to a broad range of support, advocacy and basic needs programs within their geographic area | Among those who reported needing help with legal matters, child care, or food/ groceries/ meals, percent who said “no change has occurred,” “no progress has been made,” or the “problems have been getting worse”   | <b>53%</b>   | <b>58%</b>  | 1. 20-34 year olds  |
| 3B           | PLWHA will have increased knowledge regarding treatment issues and adherence strategies                            | Among those who received help with taking meds, percent who reported the advice was “very helpful” or “somewhat helpful”   | <b>91%</b>   | <b>91%</b>  |   |
| 4A           | Unmet benefit need [add language from Plan]  | Among those who had an annual household income below \$10,000 and t-cell count below 200, percent who reported being on Medicaid   | <b>98%</b>   | <b>96%</b>  |   |

*\* Percentage reported by new cohort is statistically significantly different than the older cohort*

**Strategic Plan: MENTAL HEALTH Work Group Objectives**  
CHAIN Performance Measures, last updated Jan. 28, 2004

| <b>Obj #</b> | <b>Objective</b>   | <b>Progress Indicator</b>  | <b>% of Original CHAIN cohort with Positive Indicator (1998-2001), n=652</b> | <b>% of New CHAIN cohort with Positive Indicator (2002-2003), n=562</b> | <b>Groups in New CHAIN cohort with statistically lower progress</b> |
|--------------|--|--|--|---|---|
| 1B-1         | PLWHA engaged in mental health care will adhere to treatment           | Among those with an objective need for mental health services (a very low MH score on a standard scale), percent who reported being fully adherent to HIV meds   | <b>61%</b>   | <b>66%</b>  | 1. Women<br>2. Blacks<br>3. Whites                                  |
| 1B-2         | PLWHA engaged in mental health care will adhere to treatment           | Among those with an objective need for mental health services (a very low MH score on a standard scale), and who reported receiving professional or supportive MH services, percent who reported being fully adherent to HIV meds                | <b>58%</b>   | <b>66%</b>  | 1. Blacks<br>2. Whites  |
| 1C-1         | PLWHA engaged in mental health care will have improved quality of life | Among those with an objective need for mental health services (a very low MH score on a standard scale), percent reporting good physical health (based on high score on standard scale)  | <b>28%</b>   | <b>48%*</b>   | 1. Whites   |
| 1C-1 (mod)   | PLWHA engaged in mental health care will have improved quality of life | Among those with an objective need for mental health services (a very low MH score on a standard scale), and who received professional MH services, percent reporting good physical health (based on high score on standard scale)               | <b>39%</b>   | <b>44%</b>  | 1. Men  |
| 1C-2         | PLWHA engaged in mental health care will have improved quality of life | Among those with an objective need for mental health services (a very low MH score on a standard scale), and who received professional OR supportive MH services, percent reporting good physical health (based on high score on standard scale) | <b>28%</b>   | <b>50%*</b>   | 1. Whites<br>2. Latinos   |

*\* Percentage reported by new cohort is statistically significantly different than the older cohort*

## Strategic Plan: Multivariate Analysis

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

| <i>Factors most significantly associated with...</i>  |   |  |  |   |
|---|---|--|--|---|
| <b>Reporting a lower physical health score</b>  | <b>Being adherent to HIV medications</b>  | <b>Reporting comprehensive medical care (provider available 24 hours, for well-visit, and for health advice)</b>   | <b>Having an episode of unstable housing in the past 6 months</b>  | <b>Experiencing barriers to medical or social services care</b>   |
| <ul style="list-style-type: none"> <li>– Original cohort</li> <li>– Problem drug users</li> <li>– T-cell less than 500</li> <li>– Age over 50 years</li> <li>– Low mental health</li> <li>– Experienced barriers</li> </ul> | <ul style="list-style-type: none"> <li>– Men</li> <li>– Latinos</li> <li>– Reporting comprehensive medical care</li> <li>– Not reporting barriers to health or social service care</li> </ul> | <ul style="list-style-type: none"> <li>– Living in Brooklyn</li> <li>– having continuous medical care</li> <li>– Being white or Latino</li> <li>– Not having low mental health score</li> <li>– Not reporting barriers to health or social service care</li> </ul> | <ul style="list-style-type: none"> <li>– New cohort</li> <li>– Men</li> <li>– Problem drug users</li> <li>– Living in Manhattan</li> <li>– Age 20-34 years</li> <li>– Current or former drug user</li> </ul> | <ul style="list-style-type: none"> <li>– Being white</li> <li>– Not reporting comprehensive medical care</li> <li>– Having a low physical health score</li> </ul> |

*Note: This analysis considered the following potential factors for each outcome – gender, age, race/ethnicity, HIV risk category, borough of residence, drug use history, mental and physical health scores, continuity of medical care, comprehensive medical care, and year of HIV diagnosis.*

## **KEY FINDINGS: HEALTH Work Group**

- Overall, a representative group of HIV-positive adults in 2002-2003 reported similar experiences and health characteristics when compared with a representative group of HIV-positive adults in 1998-2001. This suggests that the health system did not change dramatically in New York City – either for the better or for the worse – over this period of time. Among the new CHAIN cohort, approximately one-third reported t-cell counts above 500 (unchanged from the earlier cohort), and 72 percent said they were completely adherent to their HIV medications (representing a slight rise from the 67% adherence rate of the original cohort).
- In looking at their medical care, approximately three-quarters of the new cohort said they had maintained the same primary medical provider for at least a year, reported receiving medical services from their primary medical provider that met the minimal preferred HIV-primary care guidelines, and further responded that their primary care met key elements of comprehensive care (i.e., available for well visits, health advice, and accessible 24 hours a day). Conversely, one-quarter did not meet these care criteria.
- There were subgroup differences on several progress indicators. Problem drug users (that is, individuals who had ever used crack, cocaine, or heroin three or more times a week, for a month or more; or who had ever injected drugs; or who were problem alcoholics) were more likely to report poor health, as were individuals with lower t-cell counts. Black respondents were less likely to report receiving comprehensive medical care, and also less likely to report being completely adherent.
- In a multi-variate analysis that looked at the contribution of the factors associated with increased adherence, men and Latinos were two groups more likely to report being adherent, as were groups reporting comprehensive medical care and groups that did not experience barriers to health or social service care. In the original CHAIN cohort, individuals whose primary care could be considered comprehensive were 68% adherent, compared with a 59% adherence rate among those whose primary care could not be considered comprehensive. This difference grew in the new CHAIN cohort, in which 75% of individuals with comprehensive primary care were adherent, compared to a 59% adherence rate among those whose primary care did not meet the criteria for comprehensive care (data not shown).
- Individuals who reported having experienced barriers to health or social services were more likely to report low physical health scores, and also less likely to be adherent.

## **KEY FINDINGS: HOUSING Work Group**

- The representative group of HIV-positive adults in 2002-2003 was far more likely to have experienced an episode of unstable housing (28% versus 18%) and or homelessness (18% versus 10%) in the prior 6 months than were members of the original CHAIN cohort interviewed in 1998-2001. It is possible to attribute some of this variation to the difference between a new “baseline” cohort and to the group who “survived” in the original CHAIN cohort from their initial recruitment in 1994-1995. Over time, in the

original CHAIN cohort, respondents who were unstably housed were more likely to be lost to follow-up.

- Regardless as to which cohort is being measured, men were statistically more likely than women to report unstable housing or homelessness.
- In a multivariate analysis (data not shown), the other factors associated with unstable housing – regardless of which cohort is being considered – is problem drug use and the age group of 20-34 year olds.
- There was a significant increase between the original and the new CHAIN cohorts in the proportion of unstably housed individuals who received housing subsidies, lived in specialized AIDS housing, or who received some other housing services.

### **KEY FINDINGS: AOD Work Group**

- Overall, there were no statistically significant differences in the two AOD progress indicators when the new CHAIN cohort from 2002-2003 was compared with the original CHAIN cohort interviewed in 1998-2001.
- One major sub-group difference did emerge – individuals in the heterosexual HIV risk behavior category with a history of current or former drug use were more likely than individuals in other HIV risk categories to have experienced barriers to health care or social services. This was also true among the heterosexual risk behavior group if drug use history was not taken in to account.

### **KEY FINDINGS: INFRASTRUCTURE Work Group**

- Overall, there were no statistically significant differences in the Infrastructure progress indicator when the new CHAIN cohort from 2002-2003 was compared with the original CHAIN cohort interviewed in 1998-2001.
- One major sub-group difference emerged, in that women were more likely than men to have reported delaying or not getting the service they needed because they didn't know where to go for specific medical or social services.

### **KEY FINDINGS: SOCIAL SERVICES Work Group**

- Overall, there were no statistically significant differences in the progress indicators when the new CHAIN cohort from 2002-2003 was compared with the original CHAIN cohort interviewed in 1998-2001.
- The only sub-group difference was among 20-34 year olds, who were more likely to have unresolved problems in legal matters, child care, or food services than were older respondents with similar expressions of need for these services.

### **KEY FINDINGS: MENTAL HEALTH Work Group**

- Overall, several progress indicators suggested considerable improvement when the new CHAIN cohort from 2002-2003 was compared with the original CHAIN cohort interviewed in 1998-2001. Among individuals with low mental health scores on a standardized scale (less than 37.0 on the SF-36 mental component summary scale), people in the new CHAIN cohort were almost twice as likely to report good physical health scores than were respondents in the original CHAIN cohort. This finding did not vary based on whether the individuals received mental health services or not.
- White respondents with low mental health scores were significantly less likely to be adherent than Latino respondents and less likely to report good physical health than were Black respondents. The reported receipt of professional mental health services among respondents with low mental health scores did not appreciably raise their physical health scores.