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Community Health Advisory & Information Network

Briefing Report 2022-2

FIRST 100 CASES

New York City Cohort Interviews in 2021-2022

The Community Health Advisory and Information Network (CHAIN) Project is an ongoing study of people with HIV (PWH) living in New York City (NYC) and the Tri-County region. CHAIN seeks to provide data from the perspective of PWH on their needs for and encounters with health and human services as well as their physical, mental, and social well-being. During each interview round, currently about every two years, survey questions are reviewed and adjusted as needed. In 2020, CHAIN, in collaboration with CHAIN's technical review committee that includes representatives from the HIV Planning Council and the NYC Department of Health and Mental Hygiene (DOHMH), revised its questionnaire. New questions were added on service needs and utilization, use of technology and telehealth, advances in HIV medication, and the COVID-19 pandemic.

This brief report is a descriptive analysis of the first 100 respondents interviewed with the new questionnaire. It covers only the first 100 cases. Based on prior CHAIN research, the results presented below likely depart from information to be collected from the full NYC cohort.

METHODOLOGY

- Data from the first 100 interviews were collected from November 2, 2021 – June 29, 2022.
- Respondents were recruited in 2008-11 or in 2015-19. The 2015-19 recruitment focused on PWH under age 40. Results are presented separately by recruitment cohort.
- The original CHAIN sample was designed to be representative of people with diagnosed HIV who have some contact with medical and/or social services in New York City or the Tri-County northern suburban region. https://nyhiv.org/nyhiv-archive/data_chain.html

KEY FINDINGS

- Engagement with HIV medical care was high among the first 100 respondents; 80% reported missing no more than one scheduled appointment for HIV medical care in the past six months, and more than three-quarters reported taking their antiretroviral (ARV) medications exactly as prescribed, almost never missing a dose.
- Of those who knew their viral load, all reported a viral load below 200 or that they were virally suppressed.
- Almost all of the first 100 respondents received the COVID-19 vaccine, although 6% had not.
- Awareness of long-acting injectable ARV therapies was moderate and interest lower. Just under two-thirds of the first 100 respondents had heard of this new treatment option and less than a quarter were interested in getting monthly injections.
- Potential access to telehealth was high among the first 100 respondents; most had a device and sufficient service to be able to attend a telehealth visit. However, more than a third of respondents were not confident in their ability to participate in a video telehealth visit. Over half preferred in-person visits to telehealth.
- The first 100 respondents had a high level of need for housing, food, financial, and transportation assistance and multiple indicators of need for services or treatment for mental or emotional health issues.

SUMMARY OF FINDINGS

We first describe findings for the 100 CHAIN participants overall, then examine differences by recruitment cohort, given age differences (average 60.5 versus 38.2 years old) between cohorts at the time of interview.

Sample Characteristics: An almost equal number of women and men participated in the first 100 interviews (Table 1). None of the first 100 participants identified as transgender.[1] The majority of respondents were Black or Latina/Latino. Few were under the age of 35.

At the time of their interview, about one-third of respondents lived in the Bronx and another third in Brooklyn. Manhattan was the next most common borough of residence, followed by Queens, and finally Staten Island. About one quarter of those interviewed were born outside of the United States.

Few of the first 100 respondents had more than a high school education, just over three-quarters were not working, and more than one-third lived below the federal poverty threshold.[2]

Current Living Situation and Risk Behaviors: Few respondents were currently experiencing homelessness or an unstable living situation (Table 2). This is not surprising since the first 100 respondents were those with stable living situations and more easily contacted for a follow up interview.[3] About two-thirds interviewed lived alone. Almost half had a history of hard drug use (heroin, crack/cocaine, and/or methamphetamines) while current problem substance use (either hard drug use or problem drinking and hard drug use) was reported by under 10% of the first 100 respondents.

Health Status and Engagement with HIV Medical Care: Most of the first 100 respondents described their current health positively, with just over a quarter reporting their current health as "fair" or "poor" (Table 3). More than one-third of respondents had a low mental health functioning score, indicating they may have clinically significant mental health symptoms like depression, anxiety, and/or other impairments. More than two-thirds scored low on a standard scale of physical health functioning.

Seventeen respondents reported ever having the coronavirus (COVID-19) and vaccination rates against COVID-19 were high, exceeding 90%. All but two respondents were on HIV medications. Engagement with HIV medical care was high; 80% of the first 100 respondents reported they did not miss more than two scheduled HIV appointments in the past six months and more than three-quarters reported they take their ARV medications exactly as prescribed, almost never missing a dose. Only 14 respondents either intentionally stopped going to the doctor or did not have any HIV

[1] While the number is small, the CHAIN Project sample includes transgender PWH. Their experiences and viewpoints are absent from this brief report and will be included once the full NYC cohort has been interviewed.

[2] The percentage of respondents living below the federal poverty threshold is lower than that expected from the full NYC cohort. This may be due to the ease of scheduling interviews with respondents who, on average, have a higher income level than the full NYC cohort, due to the stability their relatively higher income may afford them.

[3] Housing instability is lower than anticipated among the first 100 respondents. This result is not expected to persist once the full NYC cohort has been interviewed. Harder to reach respondents, such as those in and out of medical care, those experiencing homelessness or a temporary living situation, those who change their contact information frequently, or those facing other life challenges, etc., are usually not interviewed until the end of each interview round due to difficulties locating them.

medical appointments in the six months prior to their interview. Of those who knew their viral load, all reported a viral load less than 200 or that they were virally suppressed.

Opinions on Long-Acting Injectables: In January 2021, the US Food and Drug Administration approved two drugs, cabotegravir and rilprvirine, to treat HIV. Both can be administered as long-acting injectable medications, either once per month or (since February of 2022) once every two months[4] (Venkatesan, 2022). To gauge awareness of and opinions on this new treatment option, the CHAIN Project added questions on long-acting injectables to the survey. More than half of respondents had heard of long-acting injectable medications, but less than a quarter expressed interest in using them (Table 3). None of the first 100 respondents were taking long-acting injectable HIV medications at the time of their interview.

Four themes arose from conversations with respondents about their views on long-acting injectables: satisfaction with the status quo, medication management, fear, and information (Table 4). At least a fifth of respondents were content with their current medications. Disinterested respondents repeatedly questioned why they would change what was already working for them. The difficulty and tedium of taking pills every day was raised by respondents considering injectables, while disinterested respondents cited the inconvenience of going into a clinic or office as a deterrent to considering injectables. The fear of needles was another commonly raised deterrent. Respondents expressed a preference for their doctor's advice if switching medications. The need for more information, often about others' experiences with long-acting injectables, was also mentioned repeatedly.

Access to Technology and Experiences with Telehealth: Access to devices and resources for connectivity was relatively high among the first 100 respondents (Table 5). All but one participant owned a cell phone and nearly all had a smartphone. Just over 10% did not have an email address. However, nearly one in five of those interviewed had not used the internet in the six months prior to their interview.

About one-quarter of participants had had a telehealth visit in the six months prior to their interview. The majority of these visits were for medical care or advice. When asked about the technology used to communicate with their medical provider, the most common modality was through a website and/or patient portal, mentioned by 26 respondents (data not shown). Video-conferencing was the second most common option, utilized by 24 respondents.

Nearly all of the first 100 respondents had access to telehealth technology, including both sufficient minutes on their phone for a long conversation with a provider and a device with video-conferencing capabilities (Table 5). Affordability, either the cost of a video-conferencing device (smart phone, tablet, and/or a computer in the home) or internet service was a potential telehealth barrier for 10% of respondents. Confidence in participating in a video call with a provider was low. More than one-third of respondents were not confident they knew how to join a video call. Similarly, more than one-third affirmed they would need help to use their device to join a video call. Concerns about using telehealth for medical appointments were high. More than half of the first 100 respondents were uncomfortable sharing private or personal information over the internet if attending a telehealth visit. Nearly half doubted they could establish a good rapport with their provider through a telehealth visit. More than 60% expressed a preference for in-person visits over telehealth.

[4] The questionnaire specified that long-acting injectables were available on a monthly basis during all of the first 100 interviews. A follow-up question has been added to the questionnaire to also gauge knowledge of long-acting injectables given every two months.

Service Needs and Utilization: The first 100 respondents' greatest areas of need were for housing assistance, mental health services, food assistance, financial assistance, and transportation assistance (Table 6). Just over one in five needed alcohol or drug (AOD) treatment services; only one respondent reported receiving them. Need for mental health services was high; half of respondents needed such services, while only about one-third received them. About one in five respondents needed medical case management and only 15% reported receiving it.

Nearly all respondents needed housing assistance and most also received some type of assistance. Nearly half needed food assistance, but less than a quarter reported receiving any. Not having enough money for common living expenses (rent, utilities, and/or food, etc.) or directly expressing a need for financial assistance was also reported by nearly half of the first 100 respondents. Most, more than 80%, received some sort of financial assistance. More than two in five respondents needed transportation assistance, but approximately only one in five received transportation assistance.

COHORT DIFFERENCES

In 2015, the CHAIN Project began recruiting a new cohort, limiting eligibility to PWH 40 years and younger. This recruitment was designed to refresh the sample and offset the existing cohort whose mean age in 2015 was 52. For the purposes of this report, participants recruited in 2008-2011 are referred to as the continuing cohort, while those recruited in 2015-2019 are referred to as the new cohort. The observations specific to each cohort as well as differences between the two are not necessarily representative of differences that may be observed once all interviews have been conducted. Care should be taken when interpreting these results.[5,6]

Sample Characteristics: There are several differences of note in the sample characteristics of the two cohorts. The continuing cohort was, on average, older than the new cohort, and composed of a smaller percentage of respondents born outside of the United States (Table 1). A greater percentage of the new cohort, more than one in five respondents, conducted their interview in Spanish.

At the time of their interview, the greatest percentage of continuing cohort respondents lived in Brooklyn, while the majority of the new cohort who participated in the first 100 interviews live in the Bronx. The percentage of those with a high school degree or its equivalent was far higher in the new cohort. Only about one-third of the continuing cohort lived under the federal poverty threshold, while more than 60% of the new cohort did.

Current Living Situation and Risk Behaviors: A far greater percentage of the continuing cohort lived alone relative to the new cohort (Table 2). Living with children was more commonly reported by members of the new cohort. The new cohort was also composed of a greater percentage of men who have sex with men (MSM) as well as respondents who reported never having used hard drugs.

Health Status and Engagement with HIV Medical Care: The percentage of the new cohort with low mental health functioning was nearly twice that of the continuing cohort (Table 3). Limited

[5] The majority of interviews with the new cohort were conducted from February to June 2022. The different experiences or information they may have had or received relative to the continuing cohort participants interviewed earlier may affect their responses.

[6] The low number of new cohort members (n=23) reached during the first 100 interviews is not sufficient to draw conclusions about the needs and experiences of all new cohort members, necessitating care when interpreting these results.

physical ability was more common in the continuing cohort. Three-quarters of the continuing cohort had low physical health functioning, compared to just under half of the new cohort.

A greater percentage of the new cohort reported ever having COVID-19. Vaccination rates were comparable between the two respondent groups. No members of the new cohort expressed strong aversion to the vaccine. Three members of the continuing cohort said they would definitely not get it.

Both individuals not currently taking HIV medication were from the new cohort. The only difference in engagement with HIV medical care observed between the cohorts was in ARV use. Relative to the continuing cohort, a lower percentage of the new cohort reported taking their medications exactly as prescribed, almost never missing a dose.

Opinions on Long-Acting Injectables: The continuing and new cohorts emphasized different concerns about long-acting injectables. The continuing cohort was more aware of and interested in long-acting injectables (Table 3), whereas the new cohort more commonly expressed satisfaction with their current medications (data not shown). A greater percentage of the new cohort both liked their current medications and questioned why they would change (data not shown). Only members of the continuing cohort cited the inconvenience of taking pills every day as a reason for their interest in long-acting injectables (Table 4). Members of the new cohort more frequently raised their need for more information.

Access to Technology and Experiences with Telehealth: The new cohort had, on average, greater access to and more comfort using telehealth technologies then the continuing cohort (Table 5). Cell phone ownership was comparable, but members of the new cohort had greater uncertainty about whether their phone had sufficient minutes for a long call with a provider. In comparison to the continuing cohort, a higher percentage of the new cohort had their own email address, used the internet in the past six months, and had a device capable of video calls. While a far greater percentage of the new cohort was confident in their ability to participant in a telehealth visit, fewer new cohort members reported attending a telehealth visit relative to the continuing cohort. Telehealth concerns related to sharing information over the internet or establishing a relationship with their provider were higher among continuing cohort members, while a greater percentage of the new cohort reported they lacked a private space for a telehealth visit. Continuing cohort members also more commonly expressed a general preference for in-person visits.

Service Needs and Utilization: Levels of service need differed between the continuing and new cohorts for mental health services, food assistance, financial assistance, and transportation assistance (Table 6). Need for mental health services, food assistance, financial assistance, and transportation assistance was far higher in the new cohort. A greater percentage of the continuing cohort reported receiving services for all categories except behavioral health.

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Table 1. Sample Characteristics

		All (n=100)	Recruited 2008-11 (n=77)	Recruited 2015-19 (n=23)
Average Age at Interview (standard deviation)		55.3 years (11.5)	60.5 years (6.9)	38.2 years (5.3)
Age Group	Ages 18-34	7%	0%	30%
	Ages 35-49	18%	3%	69%
	Ages 50+	75%	97%	0%
Gender	Female	49%	47%	57%
	Male	51%	53%	43%
Interview Language	English	89%	92%	78%
	Spanish	11%	8%	22%
Race/Ethnicity	White	6%	8%	0%
	Black	57%	58%	52%
	Latina/Latino	31%	26%	48%
	Other[1]	6%	8%	0%
Place of Birth	United States	72%	77%	57%
	Puerto Rico	2%	1%	4%
	Outside the United States	26%	22%	39%
Borough	Bronx	36%	29%	61%
	Brooklyn	35%	43%	9%
	Manhattan	18%	16%	26%
	Queens	7%	8%	4%
	Staten Island	4%	5%	0%
Highest Education Level	Less than HS	41%	43%	35%
	HS or GED	48%	44%	61%
	More than HS	11%	13%	4%
Current Employment Status	Full Time	6%	4%	13%
	Part Time/Irregular	18%	19%	13%
	Not Working	76%	77%	74%
Household Income Below Poverty Threshold[2]	Yes	39%	32%	61%

[1] Respondents with racial or ethnic identities other than Black, Latina/Latino, or White described themselves as mixed race, Jamaican, or declined to categorize themselves.

[2] Living below the poverty threshold is below the U.S. Census Poverty Threshold calculated by household composition and household income.

Table 2. Living Situations and Risk Behaviors

		All (n=100)	Recruited 2008-11 (n=77)	Recruited 2015-19 (n=23)
Housing Situation	Stable	94%	95%	91%
	Unstable/Doubled up[1]	4%	4%	4%
	Homeless[2]	2%	1%	4%
Household Composition	Lives alone	65%	71%	48%
	Lives with partner	13%	13%	13%
	Lives with partner and children	4%	0%	17%
	Lives with children, no other adult	6%	5%	9%
	Lives with other adults	7%	8%	4%
	Lives with children and other adults	5%	4%	9%
Risk Exposure Group	Men who have sex with men (MSM)	14%	10%	26%
	Intravenous drug use (IDU)	8%	10%	0%
	MSM & IDU	2%	1%	4%
	Heterosexual/Other	76%	78%	70%
Problem Drinking[3]	Yes	6%	5%	9%
Hard Drug Use[4]	Never	52%	48%	65%
	Past	39%	43%	26%
	Current	9%	9%	9%

[1] Unstably housed individuals are not currently in permanent housing including those in a transitional housing program, in AOD treatment housing with no other address, or temporarily doubled up with others in the past 6 months.

[2] Homeless refers to individuals who report being homeless, in a shelter, in a single room occupancy (SRO) or welfare hotel with no services, or sleeping on the street or another place not meant for sleeping in the past 6 months.

[3] Current problem drinking indicated by the CAGE assessment (Ewing, 1984) or drinking weekly or more often and consuming five or more drinks when drinking in the past 6 months.

[4] Current hard drug use indicated by any use of heroin, cocaine, crack, or methamphetamines in the past 6 months.

Table 3. Health Status and Engagement with HIV Medical Care

		All (n=100)	Recruited 2008-11 (n=77)	Recruited 2015-19 (n=23)
Current Health Status[1]	Good or better	72%	70%	78%
	Fair or poor	28%	30%	22%
Low Mental Health Functioning[2]		39%	32%	61%
Poor Physical Health Functioning[3]		69%	75%	48%
Had COVID-19, Ever		17%	11%	39%
Received COVID-19 Vaccine	Yes	93%	92%	96%
	No, but intend to	1%	1%	0%
	No, waiting to see how it works for others	1%	1%	0%
	No, will only get if required	2%	1%	4%
	No, will definitely not get it	3%	4%	0%
HIV Diagnosis Year[4]	Before 1996	38%	47%	4%
	1997-2004	37%	39%	30%
	2005-2011	20%	12%	48%
	2012 or later	4%	0%	17%
On ARVs[5]	Standard of Care	81%	82%	78%
	Other ARVs	17%	18%	13%
	No HIV medication	2%	0%	9%
Aware of long-acting injectables?[6]		62%	69%	61%
Interested in long-acting injectables?[6]		23%	27%	17%
Dropped out of care in past 6 months[7]		14%	14%	13%
Consistent Care[8]		81%	81%	83%
Adherent ARV Use[9]		76%	78%	70%
Virally Suppressed[10]		100%	100%	100%

[1] Respondents are asked, "In general, would you say your health is…" with the options of excellent, very good, good, fair, or poor.

[2] Mental Component Summary Score (MSC) ≤42.0 on MOS-SF36, indicating clinically significant mental health symptoms of depression, anxiety, and/or impairment (Ware et al., 2002).

[3] Physical Component Summary score (PCS) ≤50.0 on MOS-SF36, indicating limitations in health functioning (Ware et al., 2002).

[4] n=99, one respondent declined to give their date of HIV diagnosis. Two of the 99 were perinatally infected; their HIV diagnosis year is the year they became aware they had HIV. Respondents recruited before 2015 were not asked if they were infected at birth.

[5] Standard of care refers to highly active antiretroviral therapy regimens that are recommended, alternative, or acceptable; other ARVs may refer to treatment experienced (salvage) or non-recommended regimens prescribed for other reasons.

[6] n=92, eight respondents did not answer these questions.

[7] Intentionally stopped going to the doctor and had no HIV medical appointments for 6 months or more.

[8] No or only 1 missed scheduled appointments for HIV medical care during the past 6 months AND did not have a period of dropping out of care since last interview (defined above).

[9] Taking any recommended ARV regimen and report taking medications "exactly as prescribed, almost never missing a dose" and report not missing any medications in the two days preceding the interview. Not adherent includes those who are not taking any ARV medication (n=2) and a small number (n=15) taking medications listed under "not recommended" or "should be changed" regimens in the DHHS's guidelines in effect at the time of the interview which may include individuals on salvage regimens. Of the first 100 respondents, 2 were on salvage regimens, but both were recommended under DHHS guidelines.

[10] Self-reported most recent HIV viral load as an actual numerical value or report medical provider designation as "undetectable" or "good." Viral load of <200 copies or provider report as "undetectable" or "good" were coded as "suppressed viral load;" viral load >200 copies or provider report as "bad" were coded as "unsuppressed viral load." n=97, three respondents did not know their viral load.

Table 4. Reasons for Interest/Disinterest in Long-Acting Injectables

Reasons	%	Select Comments
Satisfaction with Status Quo		
Like current medications	23%	• *I like my medications and they are working for me.*[#] • *My medication works great. I do not want to touch what is working for me.*[#] • *I'm good with my … medication.* • *I like what I am taking now, so I don't think I want to change my medications.*
Why change?	12%	• *Why change something that's working for something that may cause other problems with my health?*[#] • *No, because it's not broke, why try and fix it? … Why introduce something new into the system then wait for it to readjust and why risk any side effects?*[#] • *I'm good with my meds. If it ain't broke, don't fix it!*[#] • *I don't want to change something that I don't know how they are going to work.*
Medication management		
Concern or interest in dose frequency	14%	• *Maybe the injections would work better for me because I don't have to take [them] everyday.*[#] • *I get tired of popping pills every day.*[#] • *The pill every day is hard to remember.*[#] • *I would rather take meds once a month than every day.*[#] • *I would like to use them because I heard you get injected once per year. I love to travel…, but I always have to come back because I don't get refills for more than 6 months. I am going to ask my doctor about this.*[#] • *Interested in them. Then I can travel to visit my family and not worry about taking the bottle of pills with me.*[#] • *[I'm] worried about … [the] frequency of those shots.*
Inconvenience	12%	• *You have to go to the hospital to get them. I ain't doing all that!*[#] • *Suppose I am not feeling good and I don't want to go get that shot that day. I don't want to miss my medications.*[#] • *I travel a lot and I don't want to go through a lot to get the medications.*[#] • *If I could take it home and do it myself, I would do it. Otherwise, no, if having to go into the office every month is necessary, no.*[#] • *I wouldn't want to go to the doctor once a month.*
Fear		
Don't like needles	20%	• *I don't like needles.*[#] • *I'm scared of [needles].*[#] • *I hate needles. I'm petrified [of] needles.*
Information		
Want doctor's recommendation	16%	• *I talked to my doctor about it and he told me to stick with Biktarvy.*[#] • *My doctor would tell me about it if it was good for me. She hasn't told me about it, so I don't want it.*[#] • *I discussed it with my doctor. She said to wait cause they're working on something more long term.*[#] • *If my doctor says so, I will change my medication. Otherwise I will continue with my regular meds.*[#] • *I don't want to jump into it unless the doctor recommends it.*
Need more information	12%	• *I heard some information about it, but not enough. I need more information [about] how they work, how often I should take it, side effects.*[#] • *I want to give it some time to see how it affects people. … I have to make sure that the injectable will benefit me.*[#] • *I am waiting to see how others are doing with the meds.* • *My meds are working for me and before I change or consider changing, I need more information.*

n=92, eight respondents did not answer these questions; [#] indicates comments given by a respondent recruited in 2008-11.

Table 5. Access to Technology and Experiences with Telehealth

		All (n=100)	Recruited 2008-11 (n=77)	Recruited 2015-19 (n=23)
Own cell phone	Yes, smart phone	95%	96%	91%
	Yes, basic phone	4%	3%	9%
	No	1%	1%	0%
Have and use own email account		88%	86%	96%
Used the internet in past 6 months		82%	78%	96%
Phone has enough minutes for long call with provider	Yes	97%	99%	91%
	No	1%	0%	4%
	Don't know	2%	1%	4%
Has device with video-conferencing ability	Yes	89%	87%	96%
	No	5%	6%	0%
	Don't know	6%	6%	4%
Know how to video-conference for appointment	Confidently know how	63%	57%	83%
	Somewhat know how	4%	4%	4%
	Don't know how/other	33%	39%	13%
Had telehealth visit with medical or social service provider in past 6 months[1]	Yes, for medical care	21%	23%	13%
	Yes, for mental health or substance use	4%	4%	4%
	Yes, for social services	2%	3%	0%
	No	76%	72%	87%
The following telehealth statements are somewhat or very true…				
I need help to use device for a video telehealth visit		38%	45%	13%
I don't have a private space for a telehealth visit		10%	9%	13%
I am concerned about providing personal or private information over the internet during a telehealth visit		52%	57%	35%
I can't afford the device or internet service needed for a telehealth visit		10%	12%	4%
I worry it will be difficult to establish a good relationship or understanding with my		46%	51%	30%
I don't feel comfortable with telehealth visits and prefer in-person visits		62%	68%	43%

[1] Respondents instructed to select all types of telehealth appointments they attended; percentage exceeds 100% because three respondents had both medical and mental health or substance use treatment telehealth appointments.

Table 6. Service Needs and Utilization

	All (n=100)	Recruited 2008-11 (n=77)	Recruited 2015-19 (n=23)
Behavioral Health			
Need AOD Treatment[1]	21%	21%	22%
Use AOD Treatment[2]	1%	0%	1%
Need Mental Health Services[3]	51%	43%	78%
Use Mental Health Services[4]	31%	27%	43%
Case Management			
Need Medical Case Management[5]	22%	21%	26%
Use Medical Case Management[6]	15%	18%	4%
Subsistence Needs			
Need Financial Assistance[7]	45%	40%	61%
Use Financial Assistance[8]	82%	86%	70%
Need Food Assistance[9]	49%	43%	70%
Use Food Assistance[10]	23%	25%	17%
Need Housing Assistance[11]	97%	96%	100%
Use Housing Assistance[12]	88%	91%	78%
Need Transportation Assistance[13]	41%	39%	48%
Use Transportation Assistance[14]	22%	23%	17%

[1] Self-reported need for help or assistance with alcohol or substance abuse treatment OR alcohol or substance abuse treatment is moderately to extremely important OR current problem drinking (screening positive on the CAGE questionnaire (Ewing, 1984) or drinking weekly or more often and drinking 5 or more drinks when drinking in past 6 months) OR current hard drug use (use of heroin, cocaine, crack, or methamphetamine in past 6 months)

[2] Any alcohol or substance use treatment services including Alcoholics Anonymous/ Narcotics Anonymous in past 6 months

[3] Self-reported need for help or assistance in emotional or psychological difficulties including relationship problems in past 6 months OR low mental health functioning (Medical Outcomes Study (MOS) SF-12v2 Mental Component Summary Score (MCS) ≤42), which indicates clinically significant mental health symptoms (Ware et. al, 2002)

[4] Any psychological or emotional counseling or therapy, including talking to a pastor or religious counselor or attending a support group in past 6 months

[5] 1) No HIV primary care in past 12 months OR (2) cessation of care or no appointments for 6 or more months OR (3) more than 2 missed scheduled appointments in past 6 months OR (4) no CD4 or viral load test in past 6 months OR (5) no ARV medications or incomplete adherence to ARVs

[6] In past 6 months, a case manager helped with at least one of the following: (1) getting a referral for specific medical services OR (2) keeping an appointment for medical care OR (3) developing a plan to take HIV medications in right way OR (4) taking ARVs

[7] Yes, if respondent did not have enough money in household for rent, utilities, food, out-of-pocket medical or dental care, or transportation in the past 6 months OR respondent self-reported need for financial assistance in the past 6 months

[8] Yes, if respondent and/ or a member of household received unemployment insurance, worker's compensation, Social Security Disability Insurance (SSDI), Social Security Insurance (SSI), Temporary Assistance for Needy Families (TANF/ welfare), and/ or a cash check from the Department of Administrative Services (DAS) or the HIV/AIDS Services Administration (HASA) in the past 6 months

[9] Food insecure (self-reported not enough money for food in past 6 months, sometimes or often not getting enough to eat, or going an entire day without eating during the past month, or self-report needing food assistance in past 6 months) OR receiving food assistance in past 6 months (meals provided in a group setting, prepared meals delivered to home, food voucher, or food from a food pantry)

[10] One or more of the following services in past 6 months: meals provided in a group setting, prepared meals delivered to home, food voucher, or food from a food pantry

[11] Homeless (individuals who describe themselves as homeless or report sleeping on the street, in a shelter, or in an SRO or welfare hotel with no services) or unstably housed (not currently in permanent housing but not literally homeless, including those in a transitional housing program, in AOD treatment housing with no other address, or temporarily doubled up with friends or family) in past 6 months; OR rent burdened (report difficulty paying rent in past 6 months or insufficient income to secure housing indicated by fair market rent (FMR)>50% of income); OR report needing help or assistance to obtain stable, secure, appropriate housing, address habitability issues (e.g., no heat, damaged wiring) or avoid eviction or other housing loss in past 6 months

[12] Received tenant-based or facility-based permanent rental assistance OR "practical" housing assistance in past 6 months that resolved need or problem or made "some" or "a great deal" of progress with resolving housing needs

[13] Self-reported need for transportation assistance for any reason, or report that a lack of transportation resulted in delayed or missed medical or social services in past 6 months, or not enough money for transportation, or limited mobility (health limits moderate activities like moving a table, carrying groceries, or pushing a vacuum cleaner "a lot" AND health limits climbing several flights of stairs "a lot")

[14] An agency provided the respondent with ambulette, ride services (e.g., RideConnect), transportation vouchers (e.g., MetroCard, bus pass), or reimbursement for use of a private vehicle in past 6 months