An Evaluation of the Relationship Between Ancillary HIV Services and Primary Medical Care

August 2000

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August 2000

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This study was supported by a grant from the Department of Health and Human Services, Health Resources and Services Administration, contract number 250-OA-13(8).

Acknowledgements:

The authors thank Mi Chen, M.S., for assistance in statistical data analysis along with Elizabeth Smith, R.N., and Raphael Hess for their aid in the design and administration of the Case Management Program (CMP) questionnaire. Also, we thank the Office of AIDS Consortia and CMP provider staff members who took the time to provide us with valuable client information.

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Executive Summary

For many individuals with access to quality medical care, HIV disease is no longer a critical short-term illness but a chronic condition giving rise to more clients requiring ongoing medical care. Programs funded by the federal Ryan White Comprehensive AIDS Resources Emergency Act (RWCA) not only provide essential medical care but also facilitate access to medical care services (e.g., case management, transportation, and translation services). These ancillary services feature ongoing assistance and enable individuals to remain in the health care system, thus reducing the likelihood of non-adherence to drug therapies. Because of the importance of maintaining the strict drug regimen, retention in care is also an important part of the overall HIV care component.

This study analyzed the relationship of ancillary services and a RWCA client's receipt of medical care and retention in the health care system. We defined a cohort in need of ancillary services in part by a questionnaire designed to identify factors relating to need (e.g., education, language, and substance use). By merging client level data files we were able to identify medical service utilization trends among the individuals in the cohort who received a high number of ancillary services and those who received few services.

Receipt of ancillary services is associated with receipt of and retention in primary medical care. We found that for those RWCA clients in need of ancillary services, a positive relationship existed between their receipt of ancillary services and their access to primary medical care. This observation held constant when we controlled for age, race, gender, and insurance status. We also found that these RWCA clients were more likely to be seen by a medical doctor at least once in three consecutive six-month periods when they received needed ancillary services. Funding of programs that provide these ancillary services should be encouraged as they provide an important link between the HIV community and medical care services.

Introduction

While the HIV/AIDS epidemic has remained a constant battle for nearly two decades, there have been major advances in the treatment of HIV disease. Clinical trials show that protease inhibitors (PIs) delay disease progression and prolong survival, especially when introduced early in the disease. Persons living with HIV (PLWH) disease who take PIs must, however, endure the side effects of the medications and adhere to a very strict regimen. Demanding dosing schedules of some anti-HIV drugs could cause people to skip doses or take less than the prescribed amount. HIV specialists have demonstrated that drug-resistant strains could develop if patients fail to follow their drug regimens.[1,2] Maintaining the PI therapy, then, must involve routine visits to a physician.

Many PLWH, however, do not have the ancillary services available to them to maintain this strict PI regimen and certain subsets of HIV-infected populations may have special ancillary service needs.[3] For example, some HIV-infected individuals do not have affordable means of transportation to get to their medical appointments.[4] HIV-positive women with children may need childcare to keep medical appointments. Many PLWH, then, must have assistance in accessing primary medical care.

As funding for HIV disease becomes limited, it is important to determine the association between ancillary services and both entry into and retention in primary health care for PLWH disease. In June 1998, the Health Resources and Services Administration (HRSA) issued a Request for Quotation (RFQ) for evaluation studies on the relationship between ancillary services and primary care. The California Department of Health Services, Office of AIDS (OA) responded to this RFQ, and received an award letter in September 1998.

Research Design

This study had two hypotheses. The first pertains to clients' access to medical care while the second was designed to measure clients' retention in medical care.

1) RWCA clients who both needed and received a high number of ancillary services were seen in primary care more often than those clients who needed the services but received few or no ancillary services.

2) RWCA clients who both needed and received ancillary services were more likely to be seen in primary medical care at least once in three consecutive six-month periods than those clients who needed the ancillary services but received few or none.

In order to test the above hypotheses, two types of clients who received primary medical care were measured: 1) clients who needed ancillary services and received a high number of these services; and 2) clients who needed ancillary services but received few or none.

Medical Care and Ancillary Service Data Collection

As the grantee for California RWCA Title II, OA distributes funds to entities known as Consortia (generally organized by county). Each Consortium is responsible for conducting a needs assessment and setting priorities to determine local HIV services. A lead agency, referred to as the fiscal agent, is responsible for administering each Consortium contract. The fiscal agent contracts with the appropriate provider agencies depending on local needs identified in the needs assessment.

Each year OA submits to HRSA an Annual Administrative Report (AAR). The AAR, compiled from reports sent to OA from each RWCA Title II Consortium, contains summary level data on the number and types of visits funded, or eligible for funding, by RWCA Consortia. Using the AAR, we were able to identify RWCA medical care providers and the number of clients they served in 1997 and 1998.

These providers collect medical and ancillary service utilization data in a variety of formats. Many of them utilize the HRSA-provided software 'Toolbox' which creates a unique record number (URN) for each individual. Only those RWCA medical providers who utilized the URN for client identification, or had their data in a format that allowed for the creation of an encrypted URN, were

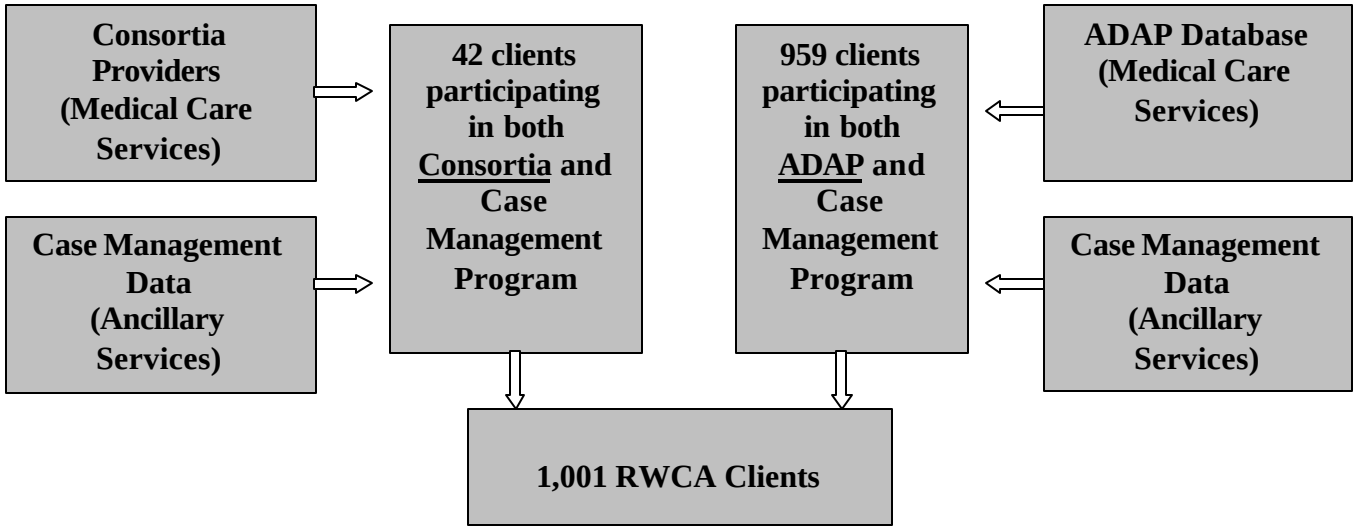
contacted for participation in this study. This URN (Attachment 1) was to be the basis for linking the records of those clients who received medical care with ancillary service information. We gathered client-level data for calendar years 1997 and 1998 from seven RWCA Consortia medical care providers identified through the AAR. This provided medical care visits for 63 unduplicated RWCA Consortia clients.

The OA Case Management Program (CMP) provides comprehensive home and community-based services to persons with AIDS or symptomatic HIV. The CMP client's HIV disease is in the advanced stages, and the purpose of the program is to maintain these clients safely in their homes in lieu of placement in a nursing facility or hospital. The program uses an interdisciplinary core case management team consisting, at a minimum, of a nurse case manager, social worker, and the attending physician in concert with the client to determine needed services. The CMP providers send client-level service utilization data on ancillary services to OA on a monthly basis. Units of ancillary services are measured consistently in CMP while the method for reporting units of service differ among Consortia. For example, one Consortia provider may report a case management visit that lasted 15 minutes as one visit while another may report a two-hour encounter as one visit. Because there is not a clear-cut standard for reporting ancillary services amongst Consortia, only the CMP data were used for ancillary service information. These ancillary services include, but are not limited to, case management, translation services, childcare, transportation, and substance use counseling.

Using the URN, the RWCA Consortia client-level data containing the number and dates of medical care services were merged with the OA's 1997 and 1998 CMP data files. This process identified 42 of the 63 RWCA Consortia clients who received both RWCA Consortia medical care services and CMP ancillary services.

Next, the OA's AIDS Drug Assistance Program (ADAP) client-level data were accessed and a file was created that included service month and URN for each client receiving ADAP services in the

two-year study period. The ADAP was legislatively established (Health and Safety Code, Sections 120925 through 120965) in October 1987 to provide drugs to individuals with HIV/AIDS who could otherwise not afford them. Each ADAP client must see a medical care provider on a regular basis in order to acquire the necessary prescription refill. Thus, it is assumed that those clients who have access to prescriptions through ADAP have access to a primary care physician and are receiving primary medical care. For this study, each month of ADAP service was considered to be equivalent to a medical care visit. Using the URN as the linking variable, the ADAP file was merged with the CMP data file and each ADAP client whose URN matched with a CMP URN was identified and included in the initial study database. This matching identified 959 clients who received both ADAP medical services and CMP ancillary services. The following flowchart depicts the matching of client files.



This process identified a total of 1,001 RWCA clients who received primary medical care either through the RWCA Consortia providers or through ADAP, and who were also enrolled in the CMP which provides a wide variety of ancillary services.

Our next step was to measure if these RWCA clients were in need of ancillary services. This process started with a review of the literature to better understand the needs surrounding the RWCA client population.

Literature Review on Indicators of Need

Our review of the literature indicates that some PLWH can encounter numerous cultural, environmental, and physical barriers to care. Substance abuse, poverty, and transportation were commonly identified as obstacles to care.[5, 6] In their Executive Summary, the Working Group on Social Harm states that stigma and discrimination impede the delivery of services by creating drastic social consequences. Even if an individual with HIV disease is healthy or is experiencing mild symptoms, it is difficult to maintain confidentiality when receiving regular medical care. Because of the fear of these consequences and the present difficulty of keeping HIV status confidential, individuals may avoid testing and do not receive subsequent access to care. The same report also states that the poor historically have a more difficult time obtaining health care and are disproportionately affected by HIV disease. Also, patients whose primary language is not English or who may have special cultural needs must have information, advice, and care in a language and format they can understand.[7]

A study of HIV-infected women showed that women who give birth with a history of drug abuse or incarceration were less likely to seek health care than other HIV-infected mothers.[8] Also, HIV disease has disproportionately affected women of color who are poor and have a limited educational background.[9] PLWH in rural areas can face long travel distances to obtain care and many have concerns regarding confidentiality.[10]

Measuring Need for Ancillary Services

As the literature review suggests, many of the populations served by the RWCA are confronted with economic and social issues that influence their access to medical care. To test the study hypotheses, the client's *need* for ancillary services had to be measured to identify the clients most impacted by these issues. Once identified, the clients with no hindrance in making medical appointments were deleted from the study cohort. Only then could we determine if the clients who both needed and received ancillary services more readily accessed medical care services than clients who

needed but did not receive ancillary services. For this study, a client's need for these ancillary services was determined through 11 variables routinely collected by CMP and through a one-page questionnaire. The 11 CMP variables included age, gender, race, AIDS status, poverty (income below 300% of Federal Poverty Income Guidelines), homeless (yes/no), mental competence, health insurance (yes/no), men who have sex with men (MSM), injection drug user (IDU), and heterosexual contact with a high-risk individual.

The need questionnaire (Attachment 2) was designed to gather information about a CMP client's social, cultural, and environmental lifestyle. It contained questions relating to factors that may impact adherence to antiretroviral regimen. These factors include education, language, family, substance abuse, etc.[11, 12,13]

We categorized the 1,001 potentially eligible clients by CMP site. Of the 41 CMP sites, 27 sites with 20 or fewer potentially eligible clients were asked to complete questionnaires on all clients. We randomly selected 20 clients for analysis from the 14 larger sites with more than 20 potentially eligible clients. A total of 554 questionnaires were sent to the 41 different CMP sites. The provider site number and client case number were printed on the top of each tool for identification so the CMP case managers could access the appropriate client files (both active and inactive) for use in completing the questionnaire. Attachment 2 contains the cover letter and a copy of the questionnaire.

Of the 554 questionnaires sent to CMP providers, 445 (80%) were completed and returned to OA. These data were entered into a database and merged with the client's CMP file, which included the 11 CMP variables referred to above. Table 1 provides the frequency of responses to the questions asked on the need questionnaire.

TABLE 1

Questionnaire Results - Completed by CMP Case Managers on 391 Selected Clients

Question	Response	N	Percent
1. Client's Education Level?	< 9th Grade or Some High School	118	30%
	12th Grade or Higher	247	63%
	Unknown	26	7%
2. Is the client responsible for others?	Yes	72	18%
	No	304	78%
	Unknown	15	4%
3. Can the client read and/or speak English?	Yes	320	82%
	No	69	17%
	Unknown	2	1%
4. Has the client missed appointments in last 12 months?	Yes	177	45%
	No	121	31%
	Unknown	93	24%
5. Does the client have a substance abuse problem?	Yes	150	38%
	No	215	55%
	Unknown	26	7%
6. Does the client have anonymity concerns?	Yes	73	19%
	No	296	76%
	Unknown	22	5%
7. Has the client ever been incarcerated?	Yes	96	25%
	No	227	58%
	Unknown	68	17%
8. Was the client on antiretroviral therapy in the last year?	Yes	293	75%
	No	29	7%
	Unknown	69	18%
9. How long has the client lived in the area?	< 6 mos.	16	4%
	6 – 12 mos.	28	7%
	> 12 mos.	336	86%
	Unknown	10	3%
10. Does the client have supportive family in the area?	Yes	213	55%
	No	152	39%
	Unknown	26	6%
11. Does the client have reliable transportation?	Yes	267	68%
	No	95	24%
	Unknown	29	8%
12. Does the community provide support services?	Yes	319	82%
	No	67	17%
	Unknown	5	1%

To determine which of the 12 need questionnaire variables and 11 CMP variables were generally correlated with a need for ancillary services, a factor analysis method was employed. This is a data reduction technique useful for reducing the number of variables being analyzed. It measures the relationships among several quantitative variables and generates 'scores' that help determine which variables correlate closely with each other. This method, and a reliability analysis, identified ten variables as reliable indicators of need for ancillary services (α=.5753). Thus, any client having one or more of the following ten need indicators was defined as being in need of ancillary services:

1. Education Level (some high school or less)
2. Responsibility for Others
3. Language Barriers
4. Substance Abuse
5. Anonymity Concerns
6. History of Incarceration
7. Unreliable Transportation
8. IDU Risk Category
9. Poverty
10. Heterosexual Contact with High Risk Individual

Of the 445 clients we analyzed, 54 (12%) were determined to have no need of ancillary services and were deleted from the study cohort. The final study cohort consisted of 391 individuals identified as needing ancillary services. Our merged client-level data files contained information relating to medical care[1] and ancillary service visits for these 391 individuals.

Results

Characteristics of Study Clients

A comparison of the demographic profile of the clients in the study cohort and California statewide AIDS cases (Table 2) reveals that the study cohort consisted of larger proportions of women, Latino, Native American, and IDU clients.

[1] Medical care is defined as office-based medical services, emergency department services, skilled nursing, intermediate care, long-term care, and specialized health services focusing on the prevention of illness and the ongoing management of chronic conditions and acute health problems. Medical care includes but is not limited to prescribing and managing medication therapy.

TABLE 2
Study Cohort Compared to Statewide AIDS Cases* by Demographic Profile

	Study Cohort		Statewide AIDS Cases		
	n	**%**	**n**	**%**	**p**
Gender					<0.001
Male	323	82.6	38,405	90.3	
Female	68	17.4	4,107	9.7	
Race / Ethnicity					0.0119
White	192	49.1	23,102	54.3	
Latino	111	28.4	9,950	23.4	
Black	72	18.4	8,175	19.2	
Asian/Pacific Islander	9	2.3	997	2.4	
Native American	6	1.5	214	0.5	
Unknown	1	0.3	74	0.2	
Age					<0.001
<20	2	0.5	264	0.6	
20-29	34	8.7	2,539	6.0	
30-36	108	27.6	10,696	25.2	
37-44	123	31.5	15,440	36.3	
>44	124	31.7	13,573	31.9	
Exposure Category					0.021
MSM	244	62.4	28,085	66.1	
IDU	66	16.9	5,216	12.3	
Other	81	20.7	9,211	21.7	

Persons living with AIDS diagnosed by 12/31/98 and reported as of 8/31/99: CA Department of Health Services, Office of AIDS

Hypothesis Testing

To address our first study hypothesis, that RWCA clients who both needed and received a high number of ancillary services were seen in primary care more often than those clients who needed the services but received few or no ancillary services, we began by defining clients receiving a low number of ancillary services and clients receiving a high number of ancillary services. Attachment 3 displays the frequency distribution of ancillary services among the clients. Those clients who received fewer than six ancillary services in the two-year study period were included in the Low Ancillary Service Visit (LSV) category (n=132). Any client receiving over 11 ancillary services was included in the High Ancillary Service Visit (HSV) category (n=138). The 121 clients who fell in the mid-range were not

included in the testing of the first hypothesis. The mean number of medical care visits (13.41) was higher for the HSV than the LSV group (8.26; $p < .001$).

The demographic characteristics of gender, race, age, insurance status, rural versus urban, and exposure category were used next as statistical controls. For purposes of analysis, race was collapsed into one variable and measured whether the respondent was white or non-white. The age variable measured whether the client was either less than 35 or 35 and older. Insurance status was categorized as either "Yes" (the client did have some form of health insurance) or "No". The county of the service provider was used to determine if the client received services in an urban or rural area. The two exposure categories were MSM and IDU.

As shown below in Table 3, when controlling for gender, race (white vs. non-white), age (under 35 vs. 35 and older), MSM, and insurance status, the positive relationship between ancillary services and primary medical care visits (PMCV) remained statistically significant: the mean number of medical care visits was higher for those in the HSV group than those in the LSV group. There was no statistical significance in the number of medical care visits, however, when controlling for rural clients and those with IDU as their primary exposure.

TABLE 3
Significance of Selected Characteristics on Number of PMCV
by Low and High Ancillary Service Visit Categories

	LSV Group		HSV Group		t-test	P
	N	Mean PMCV	N	Mean PMCV		
Primary Medical Care Visits	**132**	**8.26**	**138**	**13.41**	**5.01**	**0.0001[a]**
Gender - Male	107	8.80	116	13.37	3.80	0.0002[a]
Gender - Female	25	5.92	22	13.59	4.81	0.0001[a]
Race –White	65	10.21	72	13.99	2.15	0.0340[c]
Race – Non-White	67	6.36	66	12.77	6.14	0.0001[a]
Age (< 35)	44	7.41	33	15.76	4.86	0.0001[a]
Age (35 and older)	88	8.68	105	12.66	3.08	0.0024[b]

	LSV Group		HSV Group		t-test	P
	N	Mean PMCV	N	Mean PMCV		
	83	9.64	95	13.94	3.03	0.0029 [b]
Non-MSM	49	5.92	43	12.23	4.97	0.0001[a]
IDU	25	7.36	17	9.65	0.88	0.3821
Non-IDU	107	8.47	121	13.93	4.91	0.0001[a]
Rural	22	13.23	15	13.93	0.18	0.8579
Urban	110	7.26	123	13.34	6.44	0.0001 [a]
Insurance Coverage	74	9.66	84	13.36	2.37	0.0192 [c]
No Insurance Coverage	58	6.47	54	13.48	2.37	0.0001[a]

[a]p<=.001 [b]p<=.01 [c]p<=.05

These findings support our first hypothesis: RWCA clients who both needed and received a high number of ancillary services were seen in primary care more often than those clients who needed the ancillary services but received few or no services.

Our second hypothesis concerned a client's retention in primary medical care. The measure of program retention for this study is defined as one or more medical care visits in at least three consecutive six-month periods. From the original 391 clients who were determined to be in need of ancillary services, we identified 135 clients who did not meet our definition of retention. Figure 1 clarifies this definition.

Figure 1

Definition of Retention in Primary Medical Care
Did the client receive at least one medical care visit in three consecutive six-month periods?

Jan – Jun 1997	Jul – Dec 1997	Jan – Jun 1998	Jul – Dec 1998	Retained?
Y	Y	Y	Y	Yes
N	Y	Y	Y	Yes
Y	N	Y	Y	No
Y	Y	Y	N	Yes

We ran logistic regression on the 391 clients with receipt of at least one medical care visit in three consecutive six-month periods (Yes/No) as the dichotomous dependent variable. The independent variables in this analysis were age, race/ethnicity, sexual orientation/gender (combined to guard against multi-collinearity), insurance status, and IDU. The number of ancillary services received by each client was also used as a continuous independent variable. Table 4 illustrates that of all the variables examined ancillary services had the only statistical significance associated with a client's retention in primary medical care**.**

TABLE 4
Significance of Selected Characteristics on Retention in Primary Medical Care

	Clients Receiving Ancillary Services	% Retained	Odds Ratio	95% CI
Ancillary Service Visits	**391**	**65.5**	**1.26**	**(1.19 – 1.34)[a]**
Age Quartiles				
<35	100	63.0	1.39	(0.70 – 2.77)
35-39	99	61.6	1.00	*Reference*
40-46	95	64.2	1.26	(0.63 – 2.53)
47+	93	74.2	1.97	(0.94 – 4.13)
Race/Ethnicity				
White	192	68.8	1.00	*Reference*
Black	72	56.9	0.68	(0.34 – 1.35)
Latino	111	64.9	1.07	(0.57 – 1.99)
Sexual Orientation/Gender				
Gay Male	244	70.1	1.00	*Reference*
Heterosexual Male	79	57.0	0.68	(0.27-1.07)
Female	68	58.8	1.07	(0.35-1.35)
Insurance Coverage				
Yes	238	68.9	1.00	*Reference*
No	153	60.1	0.68	(0.77-2.20)

	Clients Receiving Ancillary Services	% Retained	Odds Ratio	95% CI
IDU Risk Category				
Yes	66	60.6	1.00	*Reference*
No	325	66.5	1.09	(0.56-2.12)

[a]p<=.01

These findings support the second hypothesis: RWCA clients who both needed and received a high number of ancillary services were more likely to be seen in primary medical care at least once in three consecutive six-month periods compared to those clients who needed the ancillary services but did not receive them.

Conclusions

Our analysis of the data indicates that for those RWCA clients who were in need of ancillary services, a positive relationship existed between their receipt of ancillary services and their access to primary medical care. This observation remained statistically significant when we controlled for age, race, gender, and insurance status. We also found that these RWCA clients were more likely to be seen at least once in three consecutive six-month periods by a medical doctor when they received needed ancillary services. When controlling for other variables such as race, sexual orientation, age, insurance status, and IDU drug use, we found that ancillary services had the only statistical significance associated with a client's retention in primary medical care.

Our study was limited in several ways. First, because of the comprehensive nature of the CMP and the CMP client's more advanced stage of disease, the clients studied may not be generalizable to the entire HIV-positive population. Second, as this was a convenience sampling technique, it is important to underscore that such vital needs as financial aid, transportation, or daycare may be over or underestimated in the CMP population. Third, this study assumes that an individual with HIV will actively seek primary medical care. A review of literature indicates that this may not be true. Cultural

and societal influences play a significant role in the behavior patterns of people with HIV disease, shaping their response to illness and their health-seeking behavior.[14,15,16,17] Accessing primary medical care for many is fraught with special issues, including poverty and a fear of disclosure that could lead to a loss of employment and/or rejection of family.[18] Finally, counselors reported the questionnaire data, not the clients themselves.

In conclusion, this study took an important step in examining the impact of ancillary services on the receipt of primary medical care for PLWH disease. We provided evidence that ancillary services provide a meaningful link between the HIV-infected person and medical care. Thus any RWCA program that funds ancillary services should be encouraged to continue this valuable aid to the HIV-infected community.

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Attachment 1 –Unique Record Number

THE UNIQUE RECORD NUMBER (URN)

PURPOSE

The Uniform Reporting System specifies the collection of client-level data that will later be connected or "unduplicated" across service providers and grantees. Complicating that requirement is the need to maintain the anonymity of the clients who are being reported. The Unique Record Number or URN has been designed to satisfy both of these goals.

By using pieces of information that are not likely to change (date of birth, gender, and portions of the name), a code can be generated for a client that will be the same regardless of where the client goes for services (unless, of course, the client provides different information at different service providers).

To further protect this information, the code is encrypted or scrambled. The resulting nine-digit code is called the Unique Record Number (URN) and does not resemble the original information in any way.

When constructing the URN from a client's name, birthdate, and gender code, use the following conventions:

Use the full legal name rather than commonly used names or nicknames. [ex: Charles instead of Chuck, or Dorothy instead of Dottie]. Treat a hyphenated name as a single string. [ex: Jane Evans-Ladd, the last name would be "Evans-Ladd"]. When determining first and third letters, count apostrophes and hyphens as characters.

How to handle a name change for a client:

When a client changes his or her name, the URN generated for that client will not be the same. If you have already reported information for that client based on the old URN, you will need to inform your data coordinator that the URN has changed (you will probably need to supply both the old and the new URN). If you have not reported any data on this client to your data coordinator, you will need to update your records and replace the old URN with the new URN. You should also encourage the client to provide this new information (the new name, not the URN) to each of the AIDS service agencies he or she has had contact with during this reporting period.

Encryption

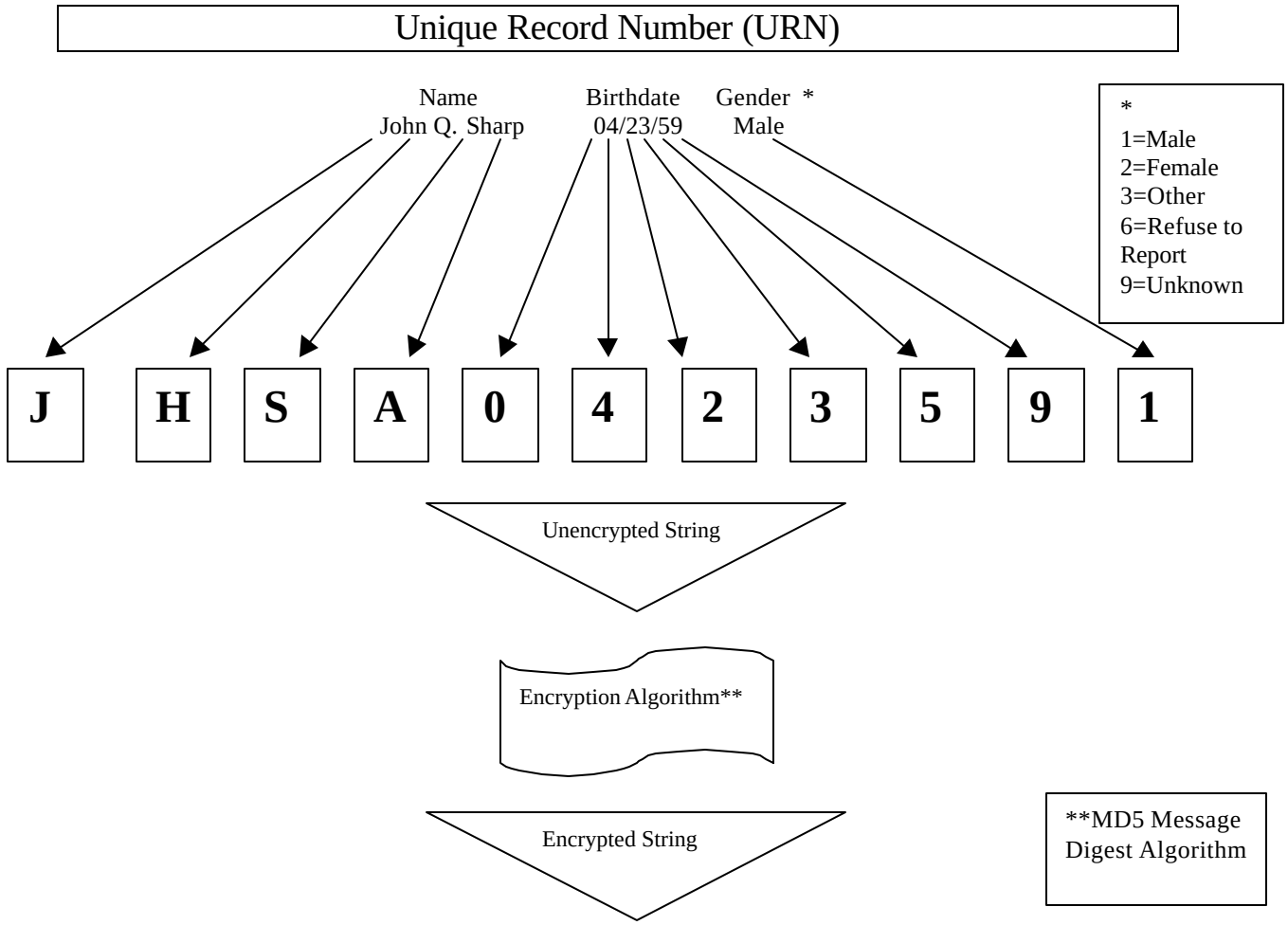
After the string of letters and numbers is constructed from the client information, it is encrypted using the HRSA URN encryption algorithm. (HRSA supported software does this automatically; other software systems can use a utility supplied in the Toolbox to encrypt the URN string.) After encryption, the 11-digit string becomes a 9-digit string. The encryption scheme is based on a message digest algorithm called MD5, developed by RSA Data Security, Inc. MD5 is a one-way hash function that transforms the un-encrypted elements into the URN, yet makes it computationally infeasible to do the reverse. The final encrypted URN will be composed of upper and lower case alpha characters (A-Z, a-z), number characters (0-9), and symbols (+ /).

How does it work?

The MD5 takes the 11-digit string and converts it into a series of 1's and 0's. These 'bits' (88 in all) are repeatedly processed with a special code until a 128-bit code is produced. Finally, 56 of the bits are dropped and the remaining 72 bits are mapped into standard characters for a total of 9 digits.

Components of the Unique Record Number (URN)

The un-encrypted string is an eleven digit alphanumeric string constructed using the following rules:



First Digit – First letter of first name, if unavailable use '9'
Second Digit - Third letter of first name, if unavailable use middle initial, if no middle initial use '9'
Third Digit - First letter of last name, if unavailable use '9'
Fourth Digit - Third letter of last name, if unavailable use '9'

Fifth & Sixth Digits - Month of birth (01-12) [Note: for months that only have one digit (i.e., Jan. – Sept.) the first digit must be a zero, not a space.]

Seventh & Eighth Digits - Day of birth (01-31) [Note: for days that only have one digit (i.e., 1 – 9) the first digit must be a zero, not a space.]

Ninth & Tenth Digits - Year of birth (00-99) [Note: do not include the century; for years that only have one digit (i.e., 1901 – 1909) the first digit must be a zero, not a space.]
NOTE: If Date of Birth is not available, use '999999'.

Eleventh Digit - Gender [M=1, F=2, Other =3, Refused to Report=6, Unknown=9]

Attachment 2 –CMP Cover Letter and Questionnaire

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, *Governor*

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 322-4634

«Name»
«Title»
«Prog»
«Address»
«StateZip»

Dear Ryan White CARE Act Provider,

The California Department of Health Services, Office of AIDS (OA) is conducting a study that examines the relationship between Ryan White funded ancillary support services and primary medical care. The Ryan White CARE Act will be up for reauthorization in the year 2000 and with your help we can better highlight for Congress the importance of support services in helping people living with HIV (PLWH) access primary medical care. OA greatly appreciates your help in this project. The findings will be provided to all CMP projects, the U.S. Department of Health and Human Services, Health Resources and Services Administration and also presented to the American Public Health Association Conference in Chicago, November 1999.

In order to determine how CMP support services help PLWH access medical care, OA must first determine a client's level of need for services. The attached surveys are designed to help document CMP client's indicators of need for support services.

A few of your CMP clients have been randomly selected and their case number is listed on the top of each of the attached one-page survey tools. Using the case number please identify each client and complete the survey. The information should be available from client interviews and in case manager files. It is estimated that each survey form will take less than 15 minutes to complete.

After completing all forms please FAX to (916) 327-3252 or mail to Dixie L. Chan, Office of AIDS, Research and Evaluation, P.O. Box 942732, Sacramento, CA 94234-7320. **Please complete all surveys and return to OA by August 27th, 1999.** Thanks again for your help in this study. If you have any questions please do not hesitate to call me at (916) 322-4634.

Dixie L. Chan, Research Program Specialist
Office of AIDS, Research & Evaluation Section

Enclosures

Site Code: «SITE» **CASE NO: «CASE»** Client URN: «URN»

Thank you for taking the time to complete this survey on your CMP client. FAX: (916) 327-3252 **OR** mail to: Dixie Chan, Office of AIDS, P.O. Box 942732, Sacramento, CA 94234-7320.

****

Below are some questions about this client's ability to access medical care. Please check the response that best applies to the client. Include any comments regarding their level of need for support services on the back of this form.

1. What is the client's education level? Check one

❑ 8th grade or less ❑ Some High School ❑ High School/GED Completed

❑ Some College (includes technical training) ❑ Four Year College Degree ❑ Post Graduate Education

2. Is the client responsible for children or others who require child or elder care? ❑ Yes ❑ No ❑ Don't Know

3. Can the client read and speak English? ❑ Yes ❑ No ❑ Somewhat

4. Has he or she missed any medical or support service appointments in the last 12 months? ❑ Yes ❑ No ❑ Don't Know If 'YES' how many?_____

5. In your opinion, does your client have a substance abuse problem? ❑ Yes ❑ No ❑ Don't Know

6. Does your client have problems with accessing care due to anonymity concerns? ❑ Yes ❑ No ❑ Don't Know

7. Has your client ever been incarcerated? ❑ Yes ❑ No ❑ Don't Know

8. Has your client been on triple antiviral therapy in the last year? ❑ Yes ❑ No ❑ Don't Know

9. How long has your client lived in the area? ❑ Less than 6 months ❑ 6-12 months ❑ Over 12 months

10. Does your client have supportive family in the area? ❑ Yes ❑ No ❑ Don't Know

11. Does your client have access to reliable transportation? ❑ Yes ❑ No ❑ Don't Know

12. Does your client's community provide support services that may help your client access medical care? ❑ Many ❑ Some ❑ Few ❑ None

13. Does your client's health insurance cover medications? ❑ Yes ❑ No ❑ No insurance

14. What county does your client currently live in? _____

Please use the back page for comments. If you use the back page be sure to include it in FAX transmission.

Attachment 3 –Table of High and Low Ancillary Service Visits

Ancillary Service Visits by Frequency of Visits
January 1997 – December 1998

Frequency of Ancillary Services	N	%	Cumulative %	'L'=Low 'H'=High
0	1	.3	0.3	L
1	31	7.9	8.2	L
2	27	6.9	15.1	L
3	27	6.9	22.0	L
4	17	4.3	26.3	L
5	29	7.4	33.8	L
6	23	5.9	39.6	
7	18	4.6	44.2	
8	19	4.9	49.1	
9	22	5.6	54.7	
10	23	5.9	60.6	
11	16	4.1	64.7	
12	13	3.3	68.0	H
13	6	1.5	69.6	H
14	8	2.0	71.6	H
15	17	4.3	76.0	H
16	7	1.8	77.7	H
17	6	1.5	79.3	H
18	15	3.8	83.1	H
19	10	2.6	85.7	H
20	7	1.8	87.5	H
21	3	.8	88.2	H
22	7	1.8	90.0	H
23	10	2.6	92.6	H
24	23	5.9	98.5	H
25	2	.5	99.0	H
29	1	.3	99.2	H
30	1	.3	99.5	H
36	2	.5	100.0	H
TOTAL	**391**	100.0		