

Evaluation Committee  
2007-2008 Year-End Report  
June 2008

Drafted for the  
Boston Part A EMA  
HIV/AIDS Health Services  
Planning Council

Produced by



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*The Evaluation Committee of the Boston EMA HIV Health Services Planning Council  
presents its 2007-2008 Year-End Report*

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**Committee Charge**

**From the Bylaws of the Boston EMA Part A Planning Council, Section 6.4.4:**

“The Evaluation Committee shall assess the efficiency of the administrative mechanism in rapidly allocating funds within the EMA and assess the impact of Part A funding and programs within the EMA. The Evaluation Committee shall summarize and inform the Planning Council on evaluation data; develop standards of care; make recommendations to the Planning Council on priority areas for evaluation and evaluation projects; and review evaluation projects purchased by the Planning Council.”

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**Committee Membership**

*Members*

Susan Goldin, Chair  
Brian Quigley, Vice-Chair  
Brenda Bellizeare  
John Gatto  
Diane Hackett  
Hannah Lewis  
Rodney VanDerwarker

*Support Staff*

Steph Sharp, PCS  
Leela Strong, PCS  
Eileen Harrington, BPHC  
Sharon Asonganyi, BPHC

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**Committee Meetings**

Thursday, November 1, 2007	2pm-4pm	Boston Public Library
Thursday, December 6, 2007	2pm-4pm	Boston Public Library
Thursday, February 7, 2008	2pm-4pm	Boston Public Library
Thursday, March 6, 2008	2pm-4pm	Boston Public Library
Thursday, April 3, 2008	2pm-4pm	Boston Public Library
Thursday, May 29, 2008	2pm-4pm	Boston Public Library

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**Work of Committee:**

- Review Part A Evaluation Products
- Create recommendations for future Part A research and evaluation
- Prepare/present Year-End Report with recommendations for next year's Council. The Year-End Report begins with an overview of the year's work, then a review of the evaluation projects review and finally recommendations for new projects and for next year's committee.

# Overview of 2007-2008 Reviewed Evaluation Products

## ANNUAL PROJECTS

- Annual Outcomes Report FY 2006: Suffolk, Sept. 2007
- Clinical Chart Review: JSI, March 2008

## FY07-08 SPECIAL PROJECTS

- Analysis on Agency Reporting: Suffolk
  - Review consistency of reporting on client outcome scores across agencies
- Impact of Services on New Clients: Suffolk (March 2008)
- Consumer Research Literature Review
  - Review consumer studies and develop a proposal for a future study
- Standards of Care Project: JSI (March 2008)
  - Develop a Universal Standards of Care, incorporating all service categories; final product to apply to BPHC and DPH funded programs

## FY07-08 PROJECTS IN DRAFT

- Consumer Satisfaction Survey
  - Pilot satisfaction survey of consumers of HIV case management, food, and peer support services in Boston EMA. There were 2,198 mail surveys distributed to clients (812 case management, 898 food services, and 488 peer support). Goals of survey included: 1) Assess quality of services, 2) role of the service in the consumer's overall healthcare, and 3) the accessibility of services.
- 3-year Cohort Study on Health and Quality of Life of PLWH in the Boston EMA
  - Review a cohort of clients who have received services consistently (at least once per year) over the past three fiscal years (FY 2004 – FY 2006). Determine if certain demographic groups (race, sex, housing, income levels, and mode of transmission) show statistically significant changes in overall health and quality of life scores, and determine if there are statistically significant changes in overall health and quality of life scores within race/ethnic groups.

Copies of these reports may also be obtained at the PCS Office or at [www.bostonplanningcouncil.org](http://www.bostonplanningcouncil.org).

## A. Review of Reports

### Annual Outcomes Report FY06: March 2006-February 2007 (Suffolk)

Objective: To measure and track health status and quality of life for both individual clients (using unique client identifiers) and for all Part A (Title I) services. Specifically looked at any statistically significant changes in Health and Quality of Life for 1) On-going (n=3,665 FY06) and new clients (n=1,304 FY06) (*current and past 3 reporting periods*); 2) MAI on-going (n=215 FY06) and new clients (n=62 FY06) (*current and past 2 fiscal years*); 3) The 3-Year Cohort (n=3,719) (*past 3 fiscal years*); and 4) The 5-Year MAI Cohort (n=29) (*past 5 fiscal years*).

Methodology: 8 Health and 7 Quality of Life outcomes were given to providers (n=53, 12 different service categories) to select and report on 5 outcomes, over 2 reporting periods (Mar-Aug and Sept to Feb).

#### Findings:

- ❖ FY06 Outcomes received and # unduplicated clients:
  - Mar.'06-Aug.'06 (n=8,223 and n=5,729)
  - Sept.'06-Feb.'07 (n=8,994 and n=5,899)
  
- ❖ Demographic profile of on-going clients compared to new clients for FY06 was:
  - Gender: male (67% vs. 70%), female (32% vs. 20%), transgender (1% both)
  - Race: Hispanic (27% vs. 26%), White (44% both), Black (29% vs. 30%), unknown or unreported (24% vs. 23%), other (3% both)
  - Age: On average 44yrs vs. 42yrs
  - Diagnostic Category: HIV positive/not AIDS (39% vs. 43%), AIDS/CDC Defined (44% vs. 39%), HIV/AIDS Status Unknown (14% both), unknown or unreported (2% both).
  - Transmission Category: Exposed through MSM (24% vs. 27%), IDU (21% vs. 22%) and Heterosexual contact (43.3% vs. 44%).
  
- ❖ Consistent with findings in previous years, overall health outcome scores are higher than quality of life outcome scores.
  
- ❖ Medical Outcomes (CD-4 Counts and HIV Viral Loads) indicate both new and on-going clients are in good to excellent health, with scores of 82% and 78% respectively. -Comparing Year-Ends FY05 to FY06:
  - There were no statistically significant changes in individual health and quality of life outcomes for on-going clients.
  - There were 2 statistically significant changes in individual health and quality of life outcomes for new clients.
  
- ❖ Compared to on-going clients, new clients have statistically significant lower outcome scores for:
  - Ability to maintain housing (41 points lower)

- Ability to access to medical care (31 points lower )
- Network of support (15 points lower)
- Knowledge about HIV/AIDS (12 points lower).

### ***Impact of Part A Services on New Clients Over Time (January 2008) (Suffolk)***

Objective: Suffolk assessed changes in outcomes for a cohort of clients new to the Ryan White system (n=177). The purpose of this review was to identify what service mix impacts client outcomes.

Methodology: The cohort included clients new to service in the first reporting period of FY 2005, and their health and quality of life outcomes were tracked over four reporting periods from FY 2005 and FY 2006. Clients must have consistently received an outcomes assessment over the study period. The New Client Cohort's progress on Health and Quality of Life outcomes was measured by actual outcome scores and categorically by the level of change (improved, remained stable, or declined).

Findings:

- ❖ 61% had improved Health outcomes during the last reporting period of FY06.
- ❖ Statistically significant improvement in Quality of Life outcome scores by end of study period.
- ❖ Most utilized services by the New Client Cohort included (CSM, CA, Dental, and Food).
- ❖ Demographic profiles similar for both Health and Quality of Life outcomes.
- ❖ Comparing improved and declined clients on both Health and Quality of Life Outcomes:
  - Improved clients mostly used PMC, MH, SA, and PS
  - Declined clients used a greater percentage of services (8 out of 12)

1-CD-4 Counts (n=156):

- Statistically significant improvement (Fair to Good) by end of FY06.
- 37% (n=35) in declined group were receiving MAI, compared to improved (16%, n=83) and remained stable (22%, n=58)

2-Viral Loads (n=128):

- Statistically significant improvement (Fair to Good) by end of FY06.
- 40% improved (highest out of all outcomes examined).
- 56% (n=27) in declined group were receiving MAI, compared to improved (24%, n=51) and remained stable (18%, n=50)

3-Ability to Maintain Medical Care (n=77):

- Minimal improvements by end of FY06, but highest outcomes score level from FY05-FY06 (89 to 88).
- 42% (n=12) in improved group were receiving transportation, compared to declined (29%, n=48) and remained stable (17%, n=17)

4-Ability to Advocate (n=77):

- 73% remained stable or improved.

5-Level of Crisis Intervention (n=72):

- 81% remained stable or improved.

- 57% (n=14) in improved group were receiving primary medical services, compared to declined (0%, n=14) and remained stable (9%, n=44).

**Evaluation Project: Analysis on Provider Reporting FY06: March 2006-February 2007  
(Suffolk)**

Objective: Suffolk will review outcome reports on clients who have multiple report submissions. The purpose of this study is to review outcome scores on clients who access multiple services, and assess whether there is consistency in the scoring across providers/services in the Boston EMA.

Methodology: Analyzed 2 groups: 1) clients with multiple reports in the first reporting period of FY 2006 and 2) clients with multiple reports in the second reporting period of FY 2006. Comparisons were made between agencies' reporting for individual outcome scores, based on the four ranking options for outcomes scores (poor, fair, good, and excellent). Differences in outcome reporting were categorized as no difference (0), one level/status difference (1), two level/status difference (2), or three level/status difference (3) based on aggregate health and quality of life outcomes for each client. A significant difference is a 2 or 3 level/status difference.

Findings:

Mar. '06-Aug. '06

- Of the total number of outcome reports received (n=8,223) from 5,729 unduplicated clients, 72% received one report (n=4,138) and 28% (n=1,591) received 2+ reports.
- Of those who received 2+ reports (n=1,591), 71% (n=1,128) received reports from 2+ agencies and 29% (n=463) from a single agency.

Sept. 06-Feb. '07

- Of the total number of outcome reports received (n=8,994) from 5,899 unduplicated clients, 69% received one report (n=4,047) and 31% (n=1,852) received 2+ reports.
- Of those who received 2+ reports (n=1,852), 69% (n=1,286) received reports from 2+ agencies and 31% (n=566) from a single agency.
- Clients with 2+ reports from 2+ agencies for both periods:
- Consistency in reporting. Less than 10% received statistically different outcome assessments from their providers.

Mar. '06-Aug. '06:

- 62% (n=703) had no difference in status and 35% (n=332) had one level/status difference in Health outcomes.
- 59% (n=668) had no difference in status and 31% (n=317) had one level/status difference in Quality of Life outcomes.

Sept. 06-Feb. '07:

- 58% (n=745) had no difference in status and 20% (n=259) had one level/status difference in Health outcomes.
- 71% (n=908) had no difference in status and 24% (n=303) had one level/status difference in Quality of Life outcomes.
- Comparison study group:
- Clients receiving support services were more likely to have statistically significant differences in aggregate Health and Quality of Life outcomes for both study periods.

- In individual service categories, no statistical differences between the 2 groups on Health or Quality of Life outcomes were uncovered. Both groups received food services as one of the highest accessed category.
- No significant demographic differences between the 2 populations over both study periods.

### **JSI Matching Project Service Utilization and Clinical Chart Review (JSI)**

Objective: 1) Determine how extensively clients at BPHC and MDPH funded clinics are using Part A client services; 2) Identify patient factors that predict use of Part A services; 3) Establish if Part A service utilization rates vary across clinic sites; and 4) Understand how utilization of different Part A services may relate to patient outcomes.

Methodology:

JSI had data on 1,348 clients from 22 clinic sites, including some sites that are outside the Part A EMA. Those clients were compared against the 7,228 clients in the BPHC utilization database. Matched between the JSI clinical chart review database and BPHC utilization database from FY2004 data (n=442) on: client date of birth, last 4 digits of client's social security number, and sex. Clients without social security numbers (i.e., undocumented foreign-born clients) were undocumented.

Findings:

Utilization rates: Match rates ranged among the 22 clinics from 0%-79%. The clinics with the highest percent match for service utilization were of relatively small size and located in Greater Boston (Whittier, Martha Eliot, and East Boston). The clinic sites that received Part A funding for a mix of services demonstrated higher client utilization of services compared to non-funded sites.

Patient factors: Of the Matched sample, women were more likely than men to utilize Part A services. Other subgroups that predict increased utilization are: Hispanics, US born persons, persons with IDU risk but not MSM risk, previously incarcerated persons, those with active substance abuse and those with active mental illness diagnoses. Patients whose first viral load was greater than 400 were also more likely to utilize services.

Patient care outcomes: Patients using services had more advanced clinical illnesses. Characteristics related to service utilization were: hospitalization, new opportunistic infection, low DC4 count and unsuppressed viral load.

Service-specific utilization rates: JSI presented results for service categories that had 10 or more matching clients. Ten service categories were included in the findings: case management, client advocacy, complementary therapies, dental, food services, housing, mental health, peer support, substance abuse, and transportation. The most common client service received in the Matched sample was case management (57% of Matched sample). The remaining 9 service categories, in order of matching are: food services (29% of Matched sample), transportation (28%), dental (26%), peer support (25%), client advocacy (17%), housing (13%), mental health (9%), complementary therapies (5%), and substance abuse (4%).

Service-specific utilization and patient factors: Women were more likely to access 4 of the 10 services than men (case management, food, transportation, and housing). Hispanics were more likely to access 4 services (case management, transportation, peer support, and client advocacy), and Blacks were more likely to access peer support services. Individuals with prior incarceration

were more likely to use 4 services (food, transportation, peer support, and substance abuse treatment). A summary across all services is provided in the report (p. 27).

### **Comparison of Selected Outcomes Reported from Ryan White-funded Agencies to Clinic-based Data from Medical Chart Review (2003-2004) (JSI)**

Objective: 1) Determine agreement rates between outcomes reports and medical record data; 2) Identify patient factors that predict agreement rates between outcomes and medical record data; 3) Determine if agreement rates differ between agencies; and 4) In the case of disagreement, identify patterns in the extent and direction of differences.

Methodology: JSI matched the clients in their clinical database to those in the Suffolk outcomes database for three time intervals (March 2003 – August 2003, September 2003 – February 2004, and March 2004 – August 2004). In this report, JSI compared four outcomes that were both in the outcome report and in the clinical chart review: 1) CD4 count, 2) HIV viral load, 3) ability to adhere to medical therapies, and 4) level of depression.

Findings:

CD4 Count: 76% of the CD4 outcome reports were consistent with medical records. For the incidents where there were discrepancies, 86% had a difference of only one level of the outcomes four level scale. (The Suffolk scale levels are: excellent = greater than 500; good = 200-500; fair = 50-199; poor = less than 50). In addition, 70% of these cases had a poorer outcome reported CD4 value than the value in the chart review. When reviewing outcome consistency by type of program, 92% of medical programs had agreement and 65% of non-medical sites had agreement.

Viral Load: 70% of the viral load outcome reports were consistent with medical records. For the incidents where there were discrepancies, 82% had a difference of only one level of the outcomes four level scale. (The Suffolk scale levels are: excellent = less than 75; good = 75-9,999; fair = 10,000-100,000; poor = greater than 100,000). Reverse of the CD4 findings, 50% of all discrepancies had a better outcome reported viral load value than the value in the chart review. Again, as with CD4 findings, the highest rate for outcome consistency was found with medical sites.

Ability to Adhere to Medical Therapies: JSI records “yes” or “no” for adherence while Suffolk uses a four level scale (excellent = routinely adheres to medical therapies; good = frequently adheres to medical therapies; fair = erratically adheres to medical therapies; and poor = rarely adheres to medical therapies). Overall, JSI found indications that adherence reports were inconsistent with medical chart data across all levels of Suffolk adherence reports. Approximately half of the clients on whom adherence was reported had “excellent” adherence in the outcome reports; according to JSI data, ¼ of these clients had evidence of ARV adherence problems. Additionally, of the clients that Suffolk reported on as “good” or “excellent,” JSI had found ARV adherence problems in 19% of the 2003 cases and 28% of the 2004 cases.

Level of Depression: Similar to the ability to adhere to medical therapies outcome, JSI records “yes” or “no” while Suffolk uses a four level scale (excellent = not depressed; good = light depression; fair = moderate depression; and poor = severe depression). There was overall agreement on presence or absence of depression in 54% of the clients in each year analyzed. For those reported to Suffolk as having some depression, agreement in the medical chart was highest for “moderate depression” and “severe depression.” Approximately 1/3 of the “light” group was noted to have depression in the chart review.

### **Consumer Research Literature Review (Suffolk)**

Objective: In-depth research on previous and current consumer-based studies including both by EMA’s and scientific studies. The results informed the development of a proposal for a consumer study conducted by BPHC. This project will also incorporate the feedback from the Voices of Experience study. The final report will include recommended research questions, a proposed methodology with timeline, and the estimated cost of conducting a consumer-based study.

Methodology: Suffolk conducted a review of previous studies by other EMAs and scholarly research articles. Suffolk also contacted different EMAs to obtain project information and budgets. Search engines used included: PubMed, Science Direct, and MGH Ovid database. Based on literature review some recommended questions/research areas include: 1) Assessing barriers to care for PLWH in the Boston EMA, 2) Differences in future service need based on age, race, or gender, 3) How has service needs changed given transition from terminal to chronic disease (evolution of disease and impact on Boston EMA). Consumer based study led by Suffolk staff, in collaboration with JSI and DPH.

Findings:

- Most EMAs used different methods, face-to-face, surveys (handout, mailed, and online), and interviews by phone.
- Out of care consumers were located by social gathering locations or other treatment centers.
- Nearly all surveys were conducted at an agency site. Approximately 200-600 surveys were completed.
- Most surveys contained closed ended check box questions and there was some similarity on types of questions.
- On average, surveys took 30mins-60mins to complete.
- Project timelines spanned from 6-17months.
- Most EMAs were surveying service needs, identifying barriers to care, or gather data for funding prioritization.

**Note: Currently working with DPH on possibility of a large scale consumer based research project.**

### Changes to the Universal Standards of Care (JSI)

Standard	Name	Edit
1.4	Client file (p. 7)	Revised standard from old standard 1.5 to ensure that each client has a file at the agency
1.7	Progress notes (p. 7)	New standard and measure
1.8	Crisis management policy (p. 7)	Revised and simplified from old standard 1.6
1.12	Funder of last resort policy (p. 8)	New standard and measure
2.0	Client Rights and Responsibilities (p. 9-10)	New section, but some material was taken from other sections. The key addition is standard and measure 2.4
5.1	Intake (p. 18)	Revised standard from old standard 5.1 to include link to primary care
5.2	Link to case management (p. 18)	New standard to ensure all clients are linked to case management

### Changes to the Service-Specific Standards of Care

Category	Current Funding Source	Status
Acupuncture	B	Pre-existing / revised from "Complementary/Holistic Therapies" service category
Case Management*	A/B	Integrated / revised
Client Advocacy	A	Pre-existing / no major changes
Comprehensive Home-Based Medical Care	B	Integrated
Dental Services	A/B	Integrated
Drug Assistance	A/B	Integrated
Emergency Assistance	B	Pre-existing
Enhanced Medical Management Services (EMMS)	B	Integrated
Food/Nutrition	A/B	Pre-existing / no major changes
Legal Services	B	Integrated
Mental Health Services	A/B	Pre-existing / no major changes
Peer Support*	A/B	Pre-existing / revised
Primary Medical Care*	A	Integrated / changes eased ability of provider to comply with standards
Residential/Housing Support*	A/B	Pre-existing / revised
Respite Care	B	Integrated
Substance Abuse Services	A/B	Pre-existing / no major changes
Transportation	A/B	Pre-existing / no major changes

In addition, the following service categories were removed from the Universal Standards of Care (2004), as they do not receive Part A or Part B funding: Adoption/Foster Care, Day Care, Drop-In Center, Respite Care, and Volunteer Support Services.

\*Significant changes were made on this service category.

## **B. Committee Recommendations for Future Evaluation Projects**

Based on a review of the reports, the Evaluation Committee would like to present the following recommendations to the Grantee for consideration for next year's evaluation projects.

1. Evaluation of the needs of rural populations and how they differ from those of more urban areas.
2. Evaluate the characteristics of programs or services that yield better outcomes, with the intention of finding a best practices model.
3. Evaluation project which looks at the Council's list of priorities to ascertain whether these priorities are consistent with the community's perceived need.
4. Broaden consumer satisfaction survey to evaluate all Planning Council service categories.

## **C. Recommendations for 2008-2009 Evaluation Committee**

The Evaluation Committee would like to make the following recommendations to the 2008-2009 Committee.

1. Review past, present and future evaluation outcomes and recommendations at the beginning of the PC year for new members.
2. Schedule time within the committee meeting to allow for a free flow of discussion.
3. Continue to have the Grantee provide feedback on changes that have been made to evaluation projects based on Evaluation Committee input.

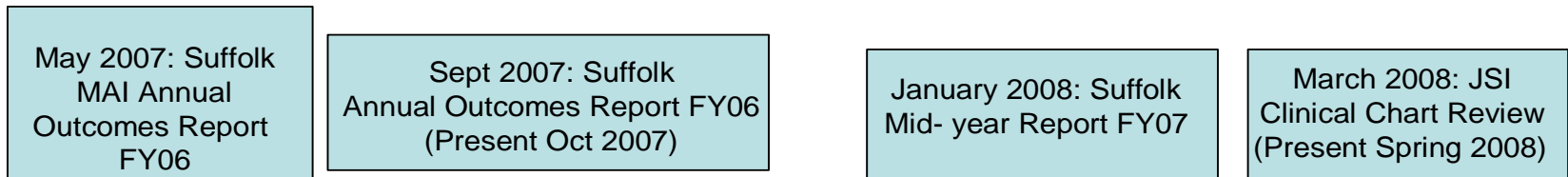
## **D. Recommendations for 2008-2009 Planning Council**

The Evaluation Committee would like to make the following recommendations to the 2008-2009 Planning Council.

1. Allow time for open forum style discussions at the Planning Council meetings
2. At the first Planning Council meeting ask Chairs of the committees to provide information on the mandate of their committee, what they have done in the past and what they want to do during the current year.

# Evaluation Products FY07

**Annual Projects**



**FY07 Special Projects**

