

Minority AIDS Initiative

Outcome Evaluation

of Access to Care and
Maintenance in Care Programs

- ACCESS TO CARE -

Prepared for the New York HIV Planning Council
Data Day 1
January 21, 2005

The New York Academy of Medicine



Programs in the Evaluation

- **13 Access to Care (ATC) Programs**

Community-based organizations, community health centers and hospitals that provide outreach and referral services to HIV-positive African Americans, Latinos and other people of color who are not in care.

- **ATC Program Objective**

The main objective of Access to Care programs is to find HIV-positive people of color who are not in health care and get them into care.

Programs in the Evaluation

Site Types of Access to Care Programs

Community-Based Organizations	6
Community Health Centers	2
Hospitals	5

Purpose of Analysis

To identify associations between various program characteristics and the programs' success in getting clients into health care (controlling for client characteristics upon entering the programs).

Analytic Model

Program Characteristics

Services available

HIV primary care

Drug treatment

Mental health

of co-located services

Service setting

Hospital vs. CBO vs. CHC

Medical vs. non-medical

Source of clients

(street outreach,
in-reach, etc.)

Point of service delivery

(hospital, homeless
shelter, etc.)

Staffing

Size of project team

of peer workers



Service and Health

outcomes:

- In/out of medical care
- Change in Functional Health Status



Controlling for Baseline

Characteristics of

Clients:

- Age
- Race
- Housing stability
- Substance use, etc.

Program Characteristics Examined

- **Services available**
 - HIV primary care
 - Drug treatment
 - Mental Health
 - # of co-located services
- **Staffing**
 - Size of salaried project team
 - # of peer workers

Program Characteristics Examined

- **Service setting**
 - Hospital vs. CBO vs. CHC
 - Medical vs. non-medical
 - Source of clients
 - street outreach, agency in-reach, referrals from other agencies, referrals from other clients, walk-ins, agency hotline
 - Point of service delivery
 - client's home, street, social service agency, hospital, community health center, outpatient drug treatment program, homeless shelter

Client Characteristics Included in Model

- Gender
- Age
- Race
- Language
- Level of Education
- Housing Stability
- Substance Use
- Functional Health Status

Outcomes Examined

- **Whether client accessed care between baseline and follow-up**
- **Change in functional health status**

Outcome: Access to Care

- We examined whether a client was in care at baseline and then whether that client was in care at their last follow-up within a year.
- “Out of Care” at baseline =
 - Client said he/she was “not receiving health care”
 - Client said he/she was “receiving health care” but was not on HIV meds
- “In Care” at baseline =
 - Client said he/she was “receiving health care” and was on HIV meds

Outcome: Access to Care

- Clients were designated as:
 - Accessed Care (program “success”)
 - Was out of care at baseline, but was in care at follow-up.
 - Lost Care/Never in Care
 - Was in care at baseline, but was out of care at follow-up; or was out of care at both baseline and follow-up.
 - Always in Care
 - Was in care at baseline and at follow-up.

Outcome: Access to Care

Overall Access to Care in all ATC Programs

	Number of Clients	Percent of Clients
Accessed Care	414	54%
Lost Care/Never in Care	60	8%
Always in Care	290	38%
TOTAL	764	100%

Findings: Program Characteristics and Access to Care, Without Controlling for Client Characteristics

- In relation to clients who were “Always in Care”:
 - Clients who “Accessed Care” . . .
 - Were 1.5 times more likely to be in Community Health Centers.
 - Came from projects with a smaller average staff size.

Findings: Program Characteristics and Access to Care, Without Controlling for Client Characteristics

- In relation to clients who were “Always in Care”:
 - Clients who “Lost Care” or were “Never in Care” were . . .
 - 1.8 times more likely to be in programs that had drug treatment as a core program element
 - 3.4 times more likely to be in Community-Based Organizations
 - 2 times as likely to be in programs that accept walk-ins or referrals from other clients

Findings: Program Characteristics and Access to Care, Including Client Characteristics in Analytic Model

- **When client characteristics are included in the analytic model, the explanatory power of program characteristics disappears.**
- **Baseline client characteristics outweigh the impact of program characteristics in explaining different rates of accessing care.**

Findings: Program Characteristics and Access to Care, Including Client Characteristics in Analytic Model

- In relation to clients who were “Always in Care”:
 - Clients who “Accessed Care” were . . .
 - Younger
 - 1.7 times more likely to be unstably housed
 - 1.6 times more likely to have used drugs within the past 3 days
 - Had lower “Social Functioning” scores

Findings: Program Characteristics and Access to Care, Including Client Characteristics in Analytic Model

- In relation to clients who were “Always in Care”:
 - Clients who “Lost Care” or were “Never in Care” ...
 - were 2 times more likely to have used drugs in the past 3 days
 - had lower “Social Functioning” scores

Findings: Program Characteristics, Client Characteristics, and Change in Functional Health Status

- **The General Health Perception and Mental Health indexes were examined.**
- **Few independent associations were found between program characteristics and change in functional health status; and between client characteristics and change in functional health status.**

Findings: Program Characteristics and Change in Functional Health Status

- **Significant associations:**
 - Clients in agencies that used agency in-reach to recruit clients were 2.4 times more likely to show a positive change in mental health status.
 - Clients in agencies that used peer educators were 1.2 times more likely to show a positive change in general health perception.

Summary/Conclusion

- A high proportion of clients were already in care at baseline, indicating that ATC programs may need to re-focus their efforts on targeting individuals who are not in care.
- Not controlling for baseline client characteristics, clients who “accessed care” were more likely than clients who were “always in care” to come from Community Health Centers or programs with smaller project staffs.
- Not controlling for baseline client characteristics, clients who “lost care” or were “never in care” were more likely than clients who were “always in care” to come from Community-Based Organizations and programs that had drug treatment as a core program element, or that accepted walk-ins or referrals from other clients.

Summary/Conclusion

- Compared to clients who were “always in care,” clients who “accessed care” were younger, more likely to be unstably housed, more likely to have used drugs within the past 3 days, and had lower “Social Functioning” scores.
- Compared to clients who were “always in care,” clients who “lost care” or were “never in care” were more likely to have used drugs within the past 3 days and had lower “Social Functioning” scores.
- Few independent associations were found between program characteristics and change in functional health status.

Summary/Conclusion

- Taken together, the analyses indicate that the program characteristics associated with “accessed care” and “lost care/never in care” – i.e., Community Health Center setting, Community-Based Organization setting, smaller project staffs, drug treatment as a core program element, accepting walk-ins or referrals from other clients – are associated with recruiting more vulnerable populations.

Limitations of Evaluation

- It is not possible to isolate causation without an experimental design.
- Because MAI programs are often embedded in a network of services offered by an agency, it is difficult to attribute outcomes solely to MAI-funded activities.
- Measures used are based on client self-report and may be biased.
- Sample is biased by differential attrition by specific client characteristics (for example, housing status and substance use status).

Current NYAM MAI Evaluation Team

- Ruth Finkelstein, Sc.D., Principal Investigator
- John Chin, Ph.D., Project Director
- Elana Behar, M.A., Project Coordinator
- Michael Botsko, M.S.W., M.Phil., Statistician
- Anthony Lewis, B.A., Research Assistant
- Charles Clarke, B.A., Data Manager