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PROGRAM EVALUATION EXAMPLE

Executive Summary: This report details the evaluations conducted for [redacted] Linkage to Care program. The overall goal of this evaluation was tot determine the extent to which the program's processes result in the enrollment of clients in the program. Evaluators designed a customized interviewing tool using open-ended questions to collect information about the program's process from staff members. Recorded interviews were conducted with three individuals comprising the entire program staff. Evaluators also extracted data from forty-one client files that were processed during the calendar year 2018. Both data sets (from interviews and client files) were analyzed to determine the factors that promote client enrollment and the factors that impede client enrollment. Evaluators found that over forty clients were referred to the program in 2018. A total of twenty-one cases were closed before the clients enrolled in the program. Of the twenty other cases analyzed, ten files represent a represent all cases that were open at the time of the evaluation. Cases were closed for one of eight reasons discussed in this report. Of the twenty-one case which were closed before client enrollment, over half were closed because the staff could not reach referred clients; outreach efforts consisted almost exclusively of attempted phone calls. Analysis of the data suggests that there are significantly more clients who could be enrolled in the program that the number of clients currently enrolled. It also suggests that factors which promote client enrollment include staffs' community outreach efforts, expedience, and in-person accommodation of clients such as the provision of transportation. Data analysis suggests that factors which impede client enrollment include a reliance on phone calls to make initial contact and a lack of readiness on the part of client, due HIV-related stigma. Implications and recommendations are discussed in proceeding pages.

Background & Purpose:

[redacted] is an HIV- service organization located in the [redacted] in Downtown Detroit. Its early intervention service program, Linkage to Care (LTC), serves individuals in Southeast Michigan who have been newly diagnosed with HIV and other people living with HIV who are not receiving HIV medical care. The purpose of Linkage to Care is to link individuals diagnosed with HIV to medical care. Linking clients to medical care promotes positive health outcomes such as viral suppression, reducing the. Transmission of HIV, and living a healthy life. Linkage to Care provides clients with assistance to the following additional services:

1. HIV Education and Risk Reductions
2. Housing
3. Identification
4. Insurance
5. Medical
6. Mental Health
7. Substance Use Treatment
8. Transportation

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The Linkage to Care program started at [redacted] in the following 2011 calendar year. The program began by serving 5 people who were new in HIV medical care. Currently, the program serves 10 clients and its contracted to serve 57. [redacted] is rethinking its outreach strategy to perform more testing at community events and increasing collaboration at other points of entry in hopes of reaching more clients who need early intervention services. The key stakeholders in the Linkage to Care program include the clients receiving services, Linkage to Care specialists, the Director of Linkage to Care programs, management staff, and funders.

Recommendations:

To conclude this evaluation, our team would like to offer recommendations for [redacted] to consider as an overview of the insight we gathered through our interviews with all three LTC staff members. Our recommendations are informed by analysis of data collected through interviews and obtained through client form documentation preceded by [redacted]. These recommendations are suggestions that may be used by [redacted] as a guide towards improving the LTC program and highlighting current successes.

Recommendation for General Structural Support:

A theme identified in interviews with LTC staff was the lack of consistency in LTC tasks and structure. Data extraction indicates that some staff called clients three times before closing at intake, while others called four, with apparent policy on the number of outreach efforts required to close a case before enrollment. The following recommendations detail structural guidance and consistency may be offered to LTC staff. These documents can include how to properly calculate units, number of times that a potential client should be contacted before closing at intake, and a general outline of a staff work day/week.

- Operationalize reasons for discharge. Recoding of cases outlined below would potentially incur *No Response to Outreach Efforts* as a reason for discharge from 48% to 67%.
- Continuation of client file analysis for a complete picture of the reasons clients are discharged from the program. Determining these reasons may help the agency decide how the program could be enhanced to improve client enrollment and retention in the program.
- Develop and provide a document on how to properly calculate units and unit standards to all LTC staff.
- Set a number of times, variety of methods, and days or times of day that a potential client should be contacted before closing at intake.

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NEEDS ASSESSMENT PRESENTATION

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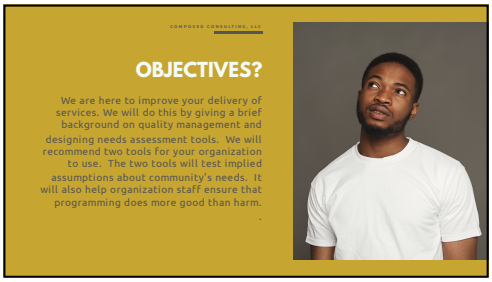

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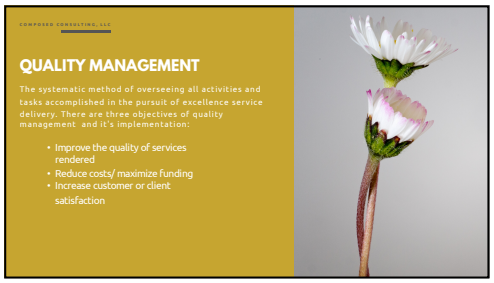

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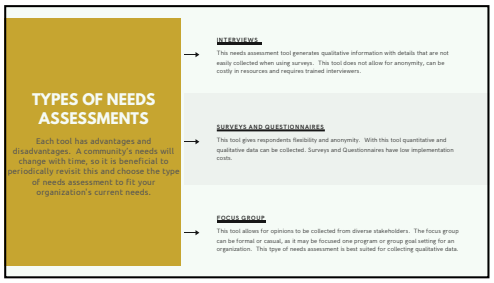

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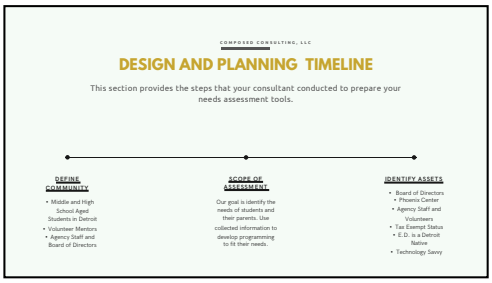

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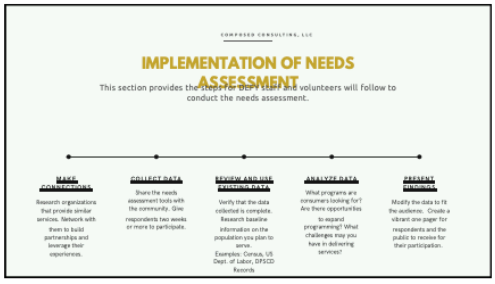

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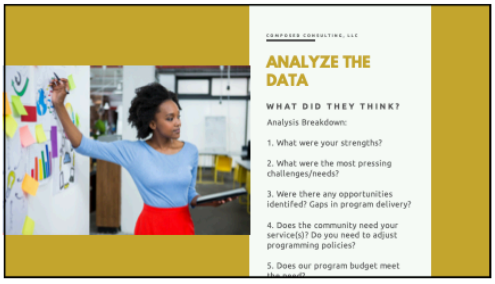

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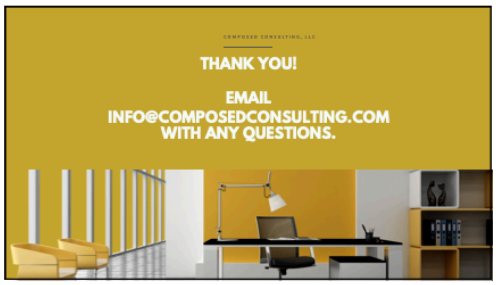

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Grant Application: The following is an excerpt from success grant application. The award amount for the Michigan Department of Health and Human Services was $600,000 each year for three years.

Statement of Need

According to MDHHS, persons with unmet need are very similar to persons with met need when comparing age at HIV diagnosis. PLWH who were young adults (ages 20-29) at HIV diagnosis have a higher proportion of unmet need when compared to other age groups (39%), followed by adults ages 30-34 (38%), and teens (36%). In general, unmet need is higher among the younger age groups than among those aged 35 or more. This is of particular significance since 33% of [redacted] case management clients are under the age of 35. By risk behavior, injection drug users (including those who are MSM and injection drug users) have the highest percentage of unmet need (41%), while 34% of MSM (including those who are MSM and injection drug users) are in the unmet need group. Given the harm reduction services provided by [redacted] to injecting drug users, it is of particular importance to ensure that IDUs who are HIV positive are linked to medical care and case management services. In terms of geography, those living in Out-State Michigan have a similar proportion of unmet need as those living in the Detroit Metro Area (DMA) (34% in Out-State and 35% in the DMA). While MDHHS 2014 treatment cascade reports show that PLWHA receiving Ryan White services are much more likely to achieve viral suppression, there are ongoing racial disparities that [redacted] will continue to address through its culturally competent community-based HIV medical case management and support services.

2. Since opening its satellite office in [redacted] in 2008, [redacted] has ensured that feedback and information is gathered from clients who access services through this office, including satisfaction surveys and meetings with clients and the local support group. While the majority of client's express great satisfaction with the continuum of care services available in [redacted] and confirm that having an office in the area has made services more accessible, PLWH in [redacted] have also indicated the need for additional transportation options to medical providers Though there are infectious disease providers in the [redacted] area, 31.25% go to IHA, University of Michigan, or even Lansing for care. [redacted] is proposing to meet this gap in service by bringing additional options for transportation, such as utilizing Lyft Business or Uber Health

concierge service. The use of concierge service will be an addition to use of bus tokens and staff transport as appropriate.

Housing costs and instability is a continued barrier for our clients. [redacted] and [redacted] counties highlight the critical need for continued support to these clients based off of their needs based off of the geographic need. [redacted] county has some of the highest rental rates in the country. The transient nature of many of the renters in the county, largely due to the [redacted] and [redacted] University communities allow for landlords to surge rental rates. Many of our clients do not have the resources to meet the costs in this county. Which is why [redacted] continues to build relationships with community stakeholders to bridge the gaps in care. The Religious Action for Affordable Housing has partnered with [redacted] since 2017 by providing funding to address the

[redacted] conducted focus groups in October 2017 for Medical Case Management clients. Understanding that each office, Ypsilanti, [redacted], and Detroit each had different gaps in services, three focus groups were conducted. All participants were asked questions regarding their case management expectations, knowledge of services offered by [redacted]-[redacted], and the overall intake process, among other questions. The responses from the focus group highlighted that clients need for food options to meet this health needs due to their dietary lifestyles and comorbidities. As previously stated the high costs of rent in [redacted] County also affects clients' ability to purchase healthier food options. Clients depend on the food bank and other food suppliers to offset those housing expenses.

3. In the changing ACA environment, [redacted] will continue to work to assure that persons eligible for health insurance through the Marketplace, Medicaid or Healthy Michigan are able to access and enroll in appropriate health insurance plans that address their total health care needs. For PLWH who are ineligible for health insurance through either of these resources, [redacted] will continue to ensure that they are able to access Ryan White funded clinical providers through established collaborative arrangements and MOAs. Additionally, [redacted] will assist uninsured PLWHA to access ADAP or other prescription assistance programs and continue to explore new collaborative agreements with providers who offer services for the uninsured. In this proposal [redacted] is requesting additional funds to expand our reach insurance navigation.