



## HIV Care, Treatment and Retention Indicators

Indicator 24: Number of HIV-positive clients receiving Highly Active Antiretroviral Therapy (HAART) from CBOs	
Description	<ul style="list-style-type: none"> <li>This indicator measures the number of HIV-positive clients that are receiving ART from CBOs.</li> </ul>
Significance	<ul style="list-style-type: none"> <li>Earlier initiation of ART treatment leads to better health outcomes (Palella, et al., 2003). Additionally, there is strong scientific evidence for HAART as prevention of HIV transmission due to lowering of viral loads (Granich, et al., 2010).</li> </ul>
Data source	<ul style="list-style-type: none"> <li>CBO administrative data</li> <li>Linking client data with administrative data held by the DTP/BCCfE</li> </ul>
Possible disaggregation	<ul style="list-style-type: none"> <li>Target population</li> <li>CD4 count and viral load at initiation of treatment</li> </ul>
Limitations	<ul style="list-style-type: none"> <li>CBO tracking issues</li> <li>The provision of ART is used as a proxy for actively taking the medication. It may be the case that pills have been dispensed but clients are not consuming the medication.</li> </ul>

Click [here](#) to download a comprehensive list of indicators in the Indicators Technical Report.





Indicator 25: Number and satisfaction of PLWHA provided with ancillary support services by CBOs	
Description	<ul style="list-style-type: none"> <li>Total number and satisfaction of PLWHA provided with ancillary support services by CBOs. Recommendations for satisfaction scales can be found in Indicator #36.</li> </ul>
Significance	<ul style="list-style-type: none"> <li>Ashman and colleagues (2002) found that the receipt of ancillary services among PLWHA was associated with receiving primary medical care from a provider and improved retention in care. Ancillary care services examined included case management, mental health and substance abuse treatment/counseling, advocacy, respite and buddy/companion services, as well as food, housing, emergency financial assistance and transportation (Ashman, et al., 2002).</li> <li>Sherer et al. (2002) similarly found that PLWHA receiving certain support services (case management, transportation, mental health and chemical dependency) were significantly more likely to receive primary health care and had improved retention in care.</li> <li>Homeless/marginally-housed PLWHA have been associated with poorer HAART access, adherence and treatment outcomes (Milloy, et al., 2012).</li> <li>Food security and HIV/AIDS are intertwined in a vicious cycle through nutritional, mental health and behavioural pathways. Normen and colleagues (2004) conducted a study to assess the level of food insecurity and hunger among HIV-positive persons accessing ART in BC. Study findings demonstrated that almost one half of the participants who were eligible for ART in BC in 1998-1999 were food insecure.</li> </ul>
Data source	<ul style="list-style-type: none"> <li>CBO client survey</li> </ul>
Possible disaggregation	<ul style="list-style-type: none"> <li>Type of ancillary support provided (e.g. housing or housing subsidies, food security and nutrition supports, mental health and substance use supports, transportation to medical appointments, etc.)</li> </ul>
Limitations	<ul style="list-style-type: none"> <li>CBO tracking issues</li> </ul>





Indicator 26: Number of referrals to ancillary support services for PLWHA provided by CBOs	
Description	<ul style="list-style-type: none"> <li>Total number and satisfaction of PLWHA provided with ancillary support services by CBOs. Recommendations for satisfaction scales can be found in Indicator #37.</li> </ul>
Significance	<ul style="list-style-type: none"> <li>Ashman and colleagues (2002) found that the receipt of ancillary services among PLWHA was associated with receiving primary medical care from a provider and improved retention in care. Ancillary care services examined included case management, mental health and substance abuse treatment/counseling, advocacy, respite and buddy/companion services, as well as good, housing, emergency financial assistance and transportation (Ashman, et al., 2002).</li> <li>Sherer et al. (2002) similarly found that PLWHA receiving certain support services (case management, transportation, mental health and chemical dependency) were significantly more likely to receive primary health care and had improved retention in care.</li> <li>Homeless/marginally-housed PLWHA have been associated with poorer HAART access, adherence and treatment outcomes (Milloy, et al., 2012).</li> <li>Food security and HIV/AIDS are intertwined in a vicious cycle through nutritional, mental health and behavioural pathways. Normen and colleagues (2004) conducted a study to assess the level of food insecurity and hunger among HIV-positive persons accessing ART in BC. Study findings demonstrated that almost one half of the participants who were eligible for ART in BC in 1998-1999 were food insecure.</li> </ul>
Data source	<ul style="list-style-type: none"> <li>CBO administrative data</li> </ul>
Possible disaggregation	<ul style="list-style-type: none"> <li>Type of support service referrals (e.g. housing support, mental health and substance use services, food security services, etc.)</li> </ul>
Limitations	<ul style="list-style-type: none"> <li>CBO tracking issues</li> <li>Lack of standardized manner to track referrals limits comparability</li> <li>Difficulty for CBOs to determine whether client followed through with referral</li> </ul>





<b>Indicator 27: Number of HIV-positive clients receiving case management services or support services that focus on connection and retention in care</b>	
Description	<ul style="list-style-type: none"> <li>Total number of HIV-positive CBO clients receiving case management services or support services, including support sessions that focus on connection to HIV care, retention in HIV care and HIV management. Case management may be delivered through in-person meetings with clients, telephone conversations or others forms of communication.</li> </ul>
Significance	<ul style="list-style-type: none"> <li>The use of case managers has demonstrated to increase likelihood of retention in care (Willis, et al., 2013).</li> </ul>
Data source	<ul style="list-style-type: none"> <li>CBO administrative data</li> </ul>
Possible disaggregation	<ul style="list-style-type: none"> <li>Clients by types of case management services received</li> </ul>
Limitations	<ul style="list-style-type: none"> <li>CBO tracking issues</li> </ul>

<b>Indicator 28: Percentage of HIV-positive clients enrolled in treatment adherence programs offered by the CBO</b>	
Description	<ul style="list-style-type: none"> <li>Percent of HIV-positive clients enrolled in a treatment adherence program offered by the CBO.</li> </ul>
Significance	<ul style="list-style-type: none"> <li>Bogart and colleagues (2012) found that participants of the Treatment Advocacy program offered at ASOs across the US exhibit better antiretroviral adherence rates than non-participants. This program facilitates clients' navigation through the medical system and provides HIV disease and treatment education through one-on-one sessions and community education forums, as well as referrals to services for health needs (e.g. mental health, substance use, housing, food/nutrition, etc.)</li> </ul>
Data source	<ul style="list-style-type: none"> <li>CBO administrative data</li> </ul>
Possible disaggregation	<ul style="list-style-type: none"> <li>Types of supports received by clients in treatment adherence programs</li> </ul>
Limitations	<ul style="list-style-type: none"> <li>CBO tracking issues</li> <li>Variation in what constitutes 'treatment adherence program'</li> </ul>





Indicator 29: Percentage change on client acuity scale for intake to reporting time	
Description	<ul style="list-style-type: none"> <li>Acuity scales are used to measure the level of client service needs and the frequency at which support should be provided along the cascade of care and prevention. There are typically four levels of acuity management: intensive for high need clients, moderate, basic and self-management/no needs/minimal management. These acuity levels are determined based on the number of points scored in the initial acuity scale assessment.</li> </ul>
Significance	<ul style="list-style-type: none"> <li>Employing the acuity scale support efficient and targeted use of resources (Boston Public Health Commission, 2014). Using the acuity scale should help to tailor services to client needs and adjust service provision as these needs change over time (Boston Public Health Commission, 2014).</li> </ul>
Measurement	<ul style="list-style-type: none"> <li>Clients would be asked a series of questions to determine acuity level. Domains of questions tend to include the following: adherence to medical care and treatment, health status, health literacy, sexual/reproductive health promotion, mental health, alcohol and drug use, housing, legal, living situation/support systems, income/personal finance management, transportation, nutrition. Clients with more intensive needs receive higher scores.</li> </ul>
Data source	<ul style="list-style-type: none"> <li>Survey with clients of CBOs</li> </ul>
Possible disaggregation	<ul style="list-style-type: none"> <li>Clients' gender, age, ethnicity, exposure group, etc.</li> </ul>
Limitations	<ul style="list-style-type: none"> <li>Resources and logistics with conducting survey with clients at multiple time points</li> </ul>





Indicator 30: Percent of HIV-positive clients that report staff at community organizations “know them as a person”	
Description	<ul style="list-style-type: none"> <li>Percent of HIV-positive clients that report staff at X organization “know them as a person”.</li> </ul>
Significance	<ul style="list-style-type: none"> <li>Studies have reported a positive association between quality of patient-provider relationships and self-reported adherence to HAART (Bakken, et al., 2000; Schneider, et al., 2004). A study conducted by Beach and colleagues (2006) demonstrated that patients who reported that their provider knows them “as a person” were more likely to receive HAART, be adherent to HAART and have undetectable serum HIV RNA.</li> </ul>
Measurement	<ul style="list-style-type: none"> <li>Beach et al. (2006) developed a single item to measure the quality of the patient-provider relationship. The item asked patients to respond, “yes”, “no”, or “don’t know” to the statement, “My HIV provider really knows me as a person.” Association between this measure and the following outcome measures was explored: (i) receipt of HAART measured by patient self-report and confirmed by chart review; (ii) adherence to HAART measured using a validated survey; (iii) serum HIV-1 RNA.</li> <li>The Dr. Peter Centre successfully employed this measure in a study exploring the effectiveness of their interventions on ART adherence and health outcomes (Turje, et al., 2012).</li> </ul>
Data source	<ul style="list-style-type: none"> <li>CBO client survey</li> </ul>
Possible disaggregation	<ul style="list-style-type: none"> <li>N/A</li> </ul>
Limitations	<ul style="list-style-type: none"> <li>Need for survey to be conducted with clients</li> <li>Self-report</li> <li>Beach et al. study speaks to medical providers, rather than staff of CBOs</li> </ul>





<b>Indicator 31: Health-related quality of life score for HIV-positive clients of CBOs</b>	
Description	<ul style="list-style-type: none"> <li>Health-related quality of life score for HIV-positive clients of CBOs.</li> </ul>
Significance	<ul style="list-style-type: none"> <li>Quality of life issues are becoming more important for PLWHA given advances in HIV treatment and resulting increases in life expectancy (Crook, et al., 2005). Basavaraj and colleagues (2010) argue that social support for PLWHA has shown a strong potential to influence health-related quality of life measures. A study comparing PLWHA that were high versus low users of CBOs found that both groups has similar health-related quality of life scores (Crook, et al., 2005). However, these authors argue that their results suggest that CBOs can enhanced health-related quality of life for persons living with HIV by increasing providers' capacity to identify and address client depression and its consequences.</li> </ul>
Measurement	<ul style="list-style-type: none"> <li>The Medical Outcomes Study HIV (MOS-HIV) Health Survey is a questionnaire widely used to measure health-related quality of life of PLWHA (Crook et al., 2005). The MOS-HIV 36-items assess physical, role, socializing and cognitive functions and pain, mental health, energy, health distress, quality of life, and health transition. Indices for each of these dimensions are scored from 0 to 100.</li> <li>The 31-item WHO Quality of Life HIV BREF Instrument assess wellbeing in adults who are HIV-positive (WHO, 2002). It covers the respondent's perception of quality of life within 6 domains: physical, psychological, independence, social, environmental and spiritual.</li> </ul>
Data source	<ul style="list-style-type: none"> <li>Client survey</li> </ul>
Possible disaggregation	<ul style="list-style-type: none"> <li>Length of time client has been associated with CBO</li> <li>High vs. low use of CBOs - can be assessed with an inventory developed by Browne and colleagues (1990) that includes questions about respondents' use of categories of direct health services/primary care, emergency room, specialists, hospital episodes and days, use of health and social professionals, and laboratory services.</li> </ul>
Limitations	<ul style="list-style-type: none"> <li>CBO tracking issues</li> <li>Lack of standardized manner to track referrals limits comparability</li> <li>Difficulty for CBOs to determine if client followed through with the referral</li> </ul>





Indicator 32: Loneliness Scale scores for people living with HIV before and after participation in support groups	
Description	<ul style="list-style-type: none"> <li>The UCLA Loneliness Scale indicates feelings of separation and isolation, and has been found to be reliable in a study comparing loneliness among people living with HIV who attend and do not attend support groups (Kalichman, et al., 1996).</li> </ul>
Significance	<ul style="list-style-type: none"> <li>Research demonstrates that social support groups offer a means of addressing the support needs of people living with HIV. A study conducted by Kalichman and colleagues (1996) found that people living with HIV that did not attend support groups were more lonely and depressed than those who did attend support groups. Loneliness among PLWHA has been found to be associated with a greatly increased likelihood of depression for these individuals (Groves, et al., 2010).</li> </ul>
Measurement	<ul style="list-style-type: none"> <li>Various versions of the UCLA Loneliness Scale (e.g. 3-item; 8-item; 20-item, etc.)</li> </ul>
Data source	<ul style="list-style-type: none"> <li>Client survey</li> </ul>
Possible disaggregation	<ul style="list-style-type: none"> <li>Type of support group</li> </ul>
Limitations	<ul style="list-style-type: none"> <li>Other factors impacting clients' loneliness outside of support groups</li> </ul>







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