

BALTIMORE CITY HEALTH DEPARTMENT

RYAN WHITE OFFICE

CLINICAL QUALITY MANAGEMENT PROGRAM (CQM)

Service Category: Psychosocial Support Services

June, 2012



TABLE OF CONTENTS

Section 1. Introduction.....	3
Section 2. Methodology.....	4
Section 3. Demographics.....	6
Section 4. Client Chart Abstractions.....	13
Section 5. Consumer Surveys.....	17
Section 6. QI Organizational Assessment.....	22
Section 7. Summary of Findings.....	25
Section 8. Discussion and Recommendations.....	26
Section 9. Acknowledgments.....	27
Appendix A. Psychosocial Support Services Standards of Care.....	28

SECTION 1. INTRODUCTION

The Baltimore City Health Department (BCHD) Clinical Quality Management Program (CQM) began in Calendar Year (CY) 2001, the purpose of which is to ensure that people living with HIV/AIDS (PLWHA) in the Greater Baltimore Eligible Metropolitan Area (EMA) have access to quality care and services consistent with the Ryan White CARE Act. The FY 2011 CQM initiatives focused on Primary Medical Care, Oral Health, Psychosocial Support (also known as Psychosocial Counseling), Hospice and Non-Medical Case management. Information presented in this report focuses exclusively on Psychosocial Support.

As defined in the Greater Baltimore HIV Health Services Planning Council Standards of Care (Standards of Care), psychosocial support services are “the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. It includes nutrition counseling provided by a non-registered dietitian but it excludes the provision of nutritional supplements.”¹

To reassess the degree to which the Standards of Care were adhered to across the EMA, data was gathered and analyzed from all Part A-funded psychosocial support vendors in the EMA. In addition to providing the results for the data collected, this report provides details of the methodology, a summary of the findings, as well as recommendations for improving the quality of psychosocial support services. The Appendices contain the Standards of Care used during the review.

Wherever possible, the FY 2010 psychosocial data are compared to data from a previous CQM psychosocial review conducted in FY 2007. However data variance can be attributed to: 1) Different reviewers, 2) Different agencies being reviewed, 3) Different records being reviewed, 4) Revisions of the Standards of Care, 5) Variations in the abstraction tool, and 6) Actual differences in performance.

¹ Greater Baltimore HIV Health Services Planning Council, *Standards of Care, Psychosocial Support*, Revised August 2009, ratified September 2009.
<http://balpc.intergroupinfo.com/doc/doc/24/Psychosocialstandards2010.pdf>

SECTION 2. METHODOLOGY

Clinical Quality Management reviews were conducted at **8** agencies providing psychosocial support services in fiscal year 2010. Data was collected through client chart abstractions, consumer surveys, and QI organizational assessments. The data collected may not reflect all Ryan White clients receiving psychosocial support services throughout the Baltimore/Towson EMA.

Psychosocial Chart Abstraction: The chart abstraction tool was designed to assess the vendor's adherence to the EMA's local standards of care. The review period focused on services provided in fiscal year 2010 (March 1, 2010 – February 28, 2011) for Part A clients. Vendors were directed to provide a random sample of charts and CQM provided two methodologies for how to pull records. CQM did not verify that the charts provided by the agencies represented a random sample. The number of charts requested from an agency was based on the total number of Ryan White clients receiving psychosocial services from that agency and guided by the 2008 HIVQUAL sampling methodology developed by the New York State Department of Health, AIDS Institute.²

For each chart reviewed, one survey instrument was completed. A total of **242** psychosocial charts were reviewed at the **8** agencies funded to provide psychosocial services. Data collected via client chart abstraction is presented in *Sections 3-4*. The number of charts reviewed at each agency ranged from **16** to **37**, with an average of **30** charts reviewed per site.

Based on service utilization data reported to BCHD by agencies receiving Part A funding, a total of **563** persons received psychosocial services during 2010.³ A total of **164 (68%)** charts were opened during the fiscal year FY'10, while a total of **48 (20%)** charts were closed during that period. The proportion of an agency's charts reviewed by CQM ranged from **21%** to **85%**. Overall **242 (43%)** psychosocial charts were reviewed during the CQM process, *Table 1*.

Consumer Survey: The consumer survey assessed quality from the client's perspective. The tool captured demographics, specific psychosocial services received, and client satisfaction with services. Vendors were instructed to provide a sample of consumers for interviews during the scheduled visit. A CQM team member administered the consumer interviews while on site. When on-site interviews were not possible, telephone interviews were conducted after obtaining client consent by the agency.

Organizational Assessment: CQM utilized a quality improvement organizational assessment checklist to measure quality improvement activities in multiple domains including quality structure, quality planning, quality performance measurement, quality improvement activities, staff involvement, consumer involvement, evaluation of the quality program, and clinical information systems. CQM staff interviewed each agency and completed the organizational assessment based on vendor responses and substantiating documentation where available. The assessment was

² New York State Department of Health, AIDS Institute. The 2008 HIVQUAL Project Sampling Methodology, August, 2009.

³ This data was obtained from the monthly Form 8s submitted to the Baltimore City Health Department (BCHD) as the administrative agency. This total is unduplicated at the vendor level, and then aggregated to give a duplicated EMA-wide count.

developed by the HIVQUAL-US program at the New York State Department of Health AIDS Institute.

4

Table 1: Psychosocial charts reviewed (N=242)

Program	Charts Reviewed	% CQM Sample	Clients Seen	% Agency Sample
JHU Moore	36	15%	85	42%
Joseph Richey Hospice	27	11%	71	38%
UMD Pediatrics	36	15%	53	68%
Anne Arundel Health Dept	29	12%	34	85%
AIDS Interfaith Residential Services	26	11%	51	51%
Light Health and Wellness	16	7%	39	41%
Sisters Together and Reaching	35	14%	56	63%
Project PLASE	37	15%	174	21%
Total	242	100%	563	43%

The client chart abstraction tool and QI organizational assessment were distributed to vendors and the Planning Council for comment prior to utilization during the reviews. CQM also conducted conference calls with all psychosocial support programs in advance of their reviews to confirm dates, locations, any additional logistics, and to answer questions specific to the tools and/or review process.

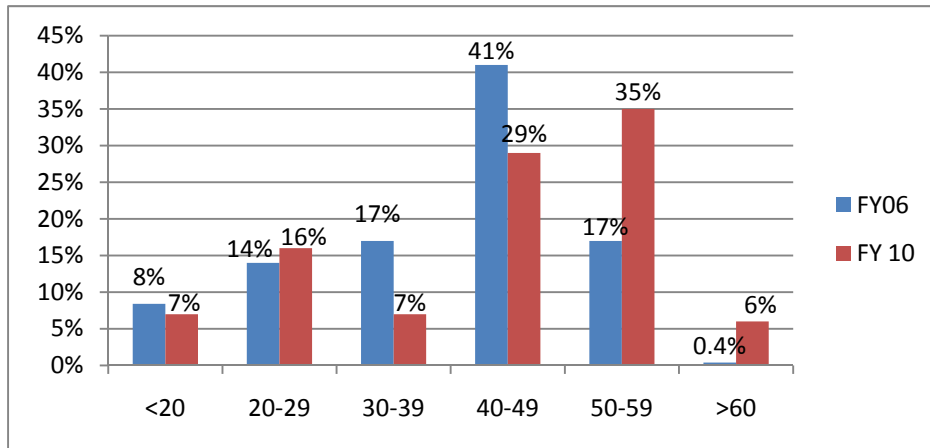
⁴ <http://www.hivguidelines.org/wp-content/uploads/HIVQUAL-OA.pdf>

SECTION 3. DEMOGRAPHICS

AGE

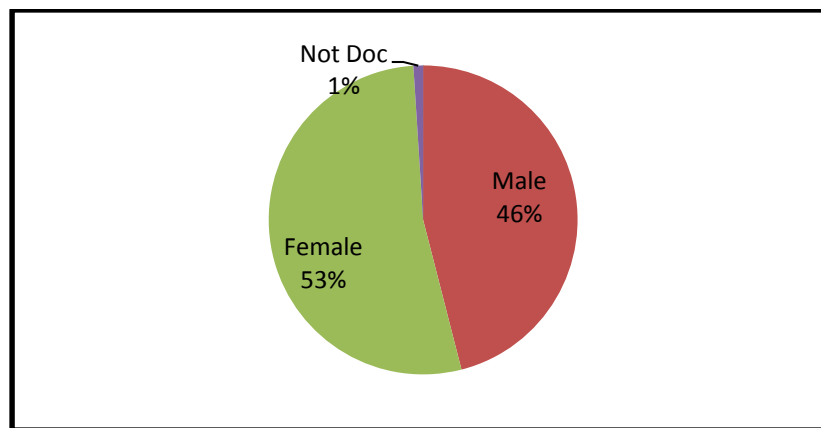
Almost two-thirds of clients were between **40** and **59** years of age as shown in *Figure 1* below. The FY10 sample of psychosocial clients included some youth under the age of 20 (**7%**). The mean age of the clients was **43** while their ages ranged from **8-78** years old. The FY10 sample showed a **24%** increase of clients over the age of 50 compared to the 2006 data. (Note, percentage totals may be slightly above or below **100%** due to rounding).

Figure 1: Age Distribution, N=241



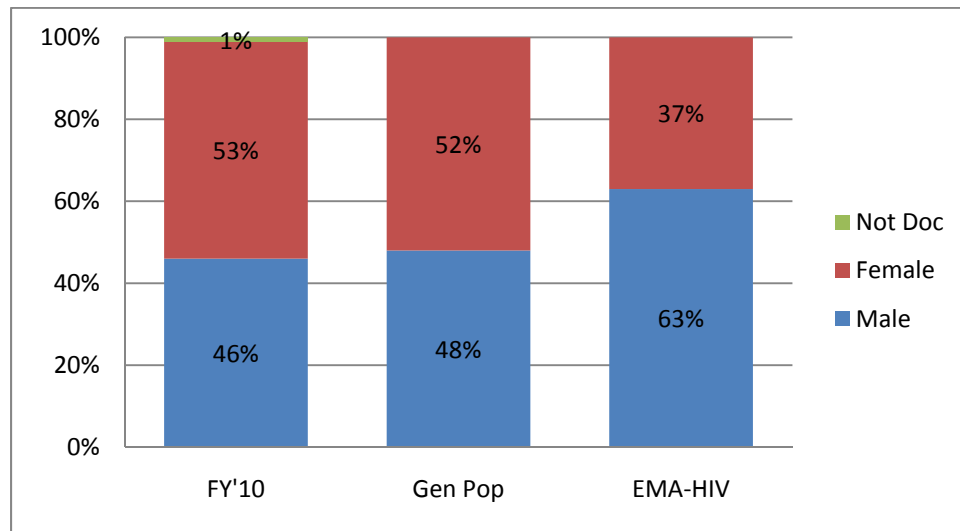
GENDER

Figure 2: Gender Distribution; N=241



Gender was almost evenly distributed, with males comprising **46%** and females **53%**. Gender was not documented/missing in **1%** of the charts. This distribution is similar to that of the general population in the EMA, but not to the HIV population in the EMA which has a higher proportion of males (*see figure 3*).

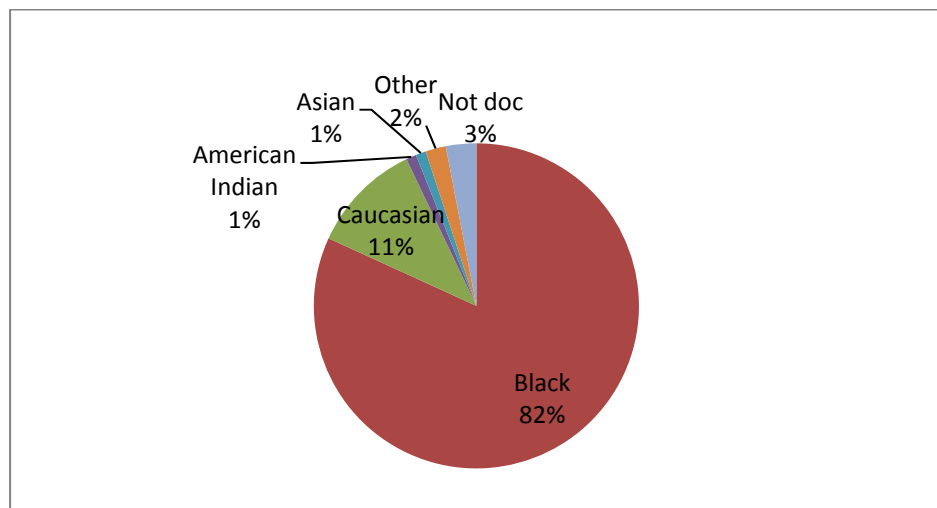
Figure 3: Comparison of gender distribution in FY'10 psychosocial sample, general population and EMA HIV population



RACE

Most of the psychosocial charts reviewed belonged to African-American (**82%**) clients, while **11%** were Caucasian. Race/ethnicity was missing in **3%** of charts reviewed. There were **2** clients who were Hispanic and mixed race respectively and listed as 'Other' in *Figure 4*. This represented less than **1%** each of the total charts reviewed.

Figure 4: Race ethnicity distribution, N=242



RISK FACTOR

In FY'10, the most commonly documented risk factor in psychosocial charts (*Figure 5*) was heterosexual transmission (**30%**), followed by IDU (**22%**) and perinatal transmission (**17%**). The main difference between this sample and the one reviewed in FY'06 was the higher proportion of

clients who acquired HIV perinatally due to visiting a pediatric site (17% vs. 8% in FY'06). More IDU and perinatal transmission was seen in 2010 vs. 2006, *Figure 6*. Risk factor was not documented in 9% of psychosocial charts reviewed in FY'10.

Figure 5: Distribution of risk factors in FY'10 compared to FY'06; N=240

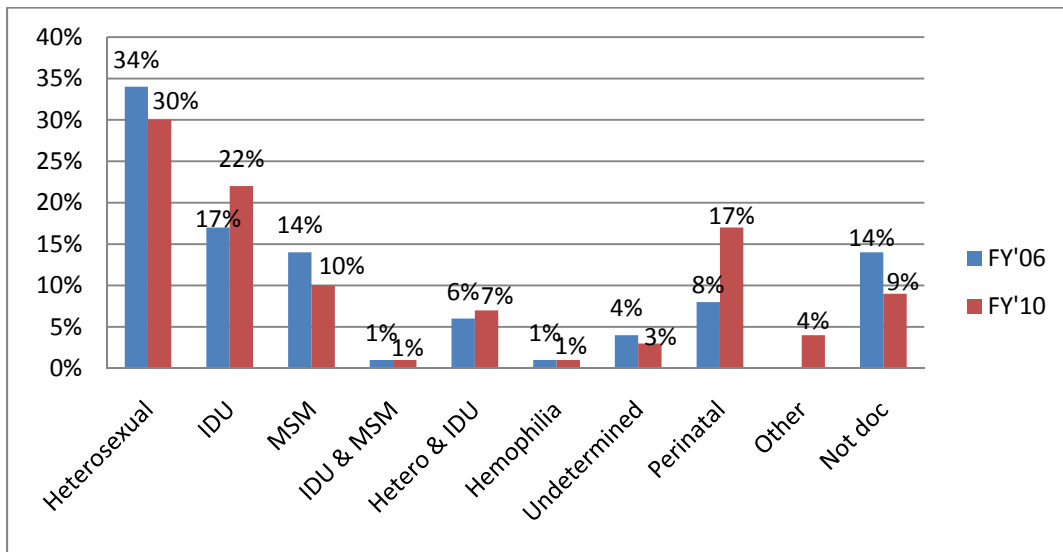
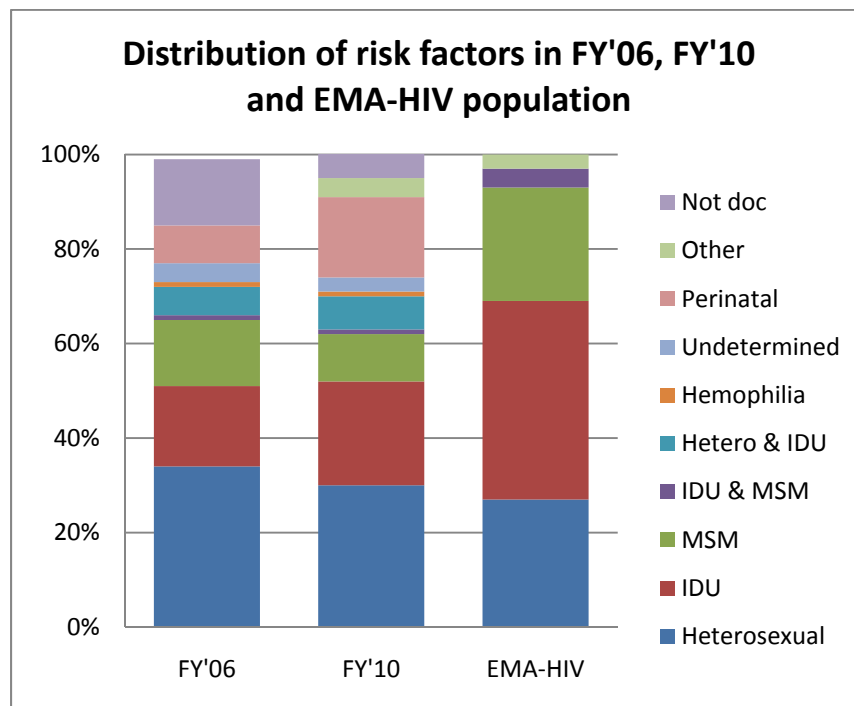


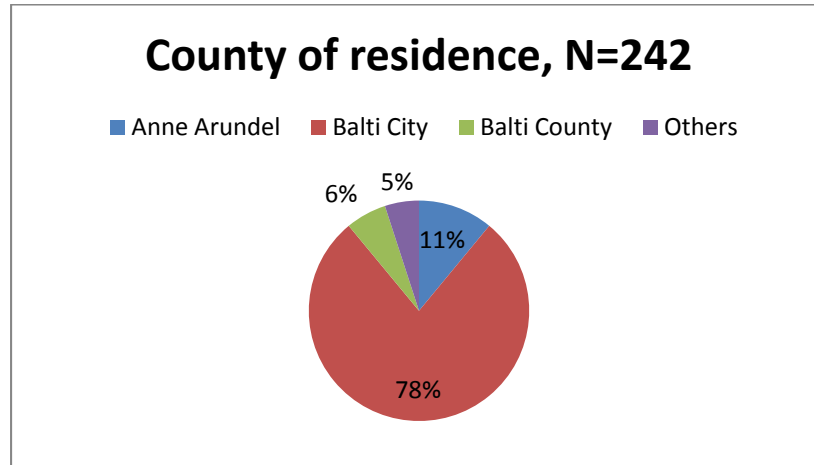
Figure 6: Comparison of risk factor distribution in FY '06, FY'10 and EMA HIV population



RESIDENCY

Client zip codes were used to obtain their county of residence. Most (**78%**) clients resided in Baltimore City, **6%** in Baltimore County and **11%** in Anne Arundel County (*Figure 7*). There were **12** clients in the 'other' category, comprising of: **2** clients from Howard County (**0.8%**); **2** from Harford County (**0.8%**); **2** from Carroll County (**0.8%**); **1** client whose zip code was missing (**0.4%**) and **5** clients (**2%**) from the Virginia-DC EMA.

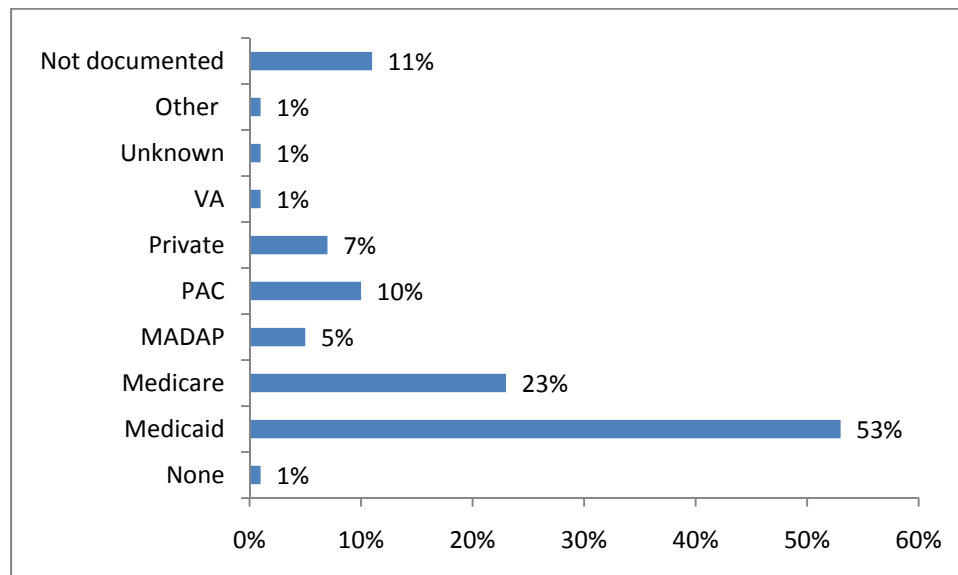
Figure 7: County of residence, N=242



INSURANCE

The most commonly documented form of insurance was Medicaid (**53%**), followed by Medicare (**23%**), PAC (**10%**) and private insurance (**7%**). Note that totals exceed **100%** as some clients had more than one type of insurance. Also, **11%** of charts reviewed did not document insurance type.

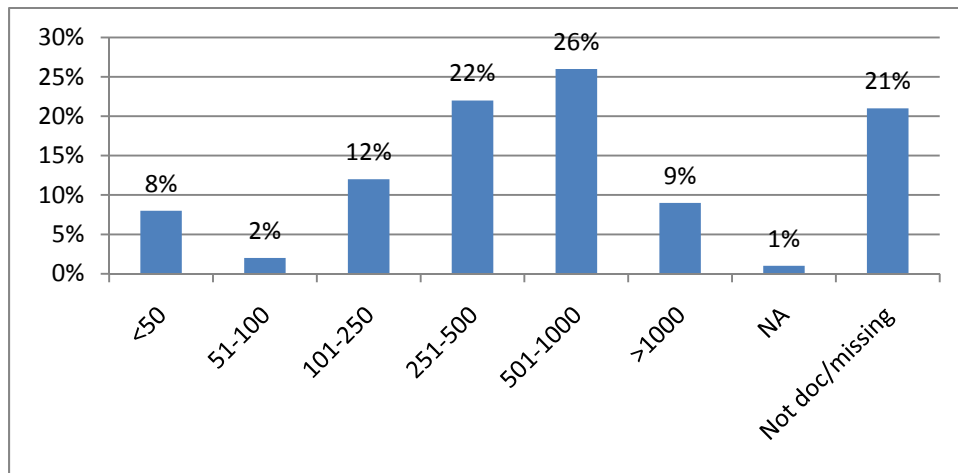
Figure 8: Insurance Coverage distribution



LABORATORY VALUES

CD4 distribution is shown in *Figure 9* below. Most of the charts sampled showed about half of the clients had CD4 counts from 251-1000. There were **44 patients (18%)** in our sample who met the CDC-definition of AIDS (CD4 T-cell count below 200mm/ μ l). CD4 count was not documented in **21%** of charts reviewed.

Figure 9: CD4 Distribution; N=242



As shown in *Figure 10*, viral load distribution showed viral load suppression to undetectable levels (marked as undetectable in charts or under 50 copies/ml) in over a third of the charts reviewed (**38%**). About **8%** of clients had viral loads of over 20,000copies/ml. More than a quarter of the charts (**27%**) lacked documentation on viral load.

Figure 10: Viral Load Distribution, N=242

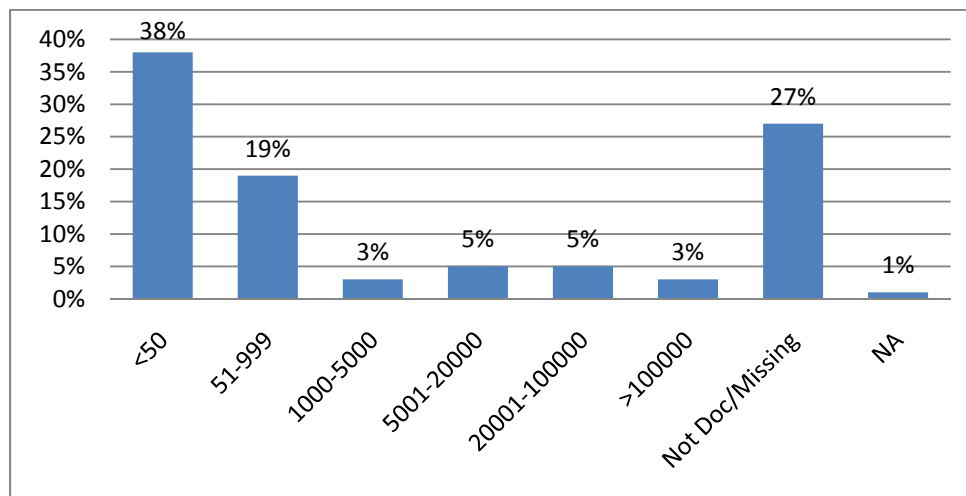


Table 2: Viral load suppression by race, risk factor and gender

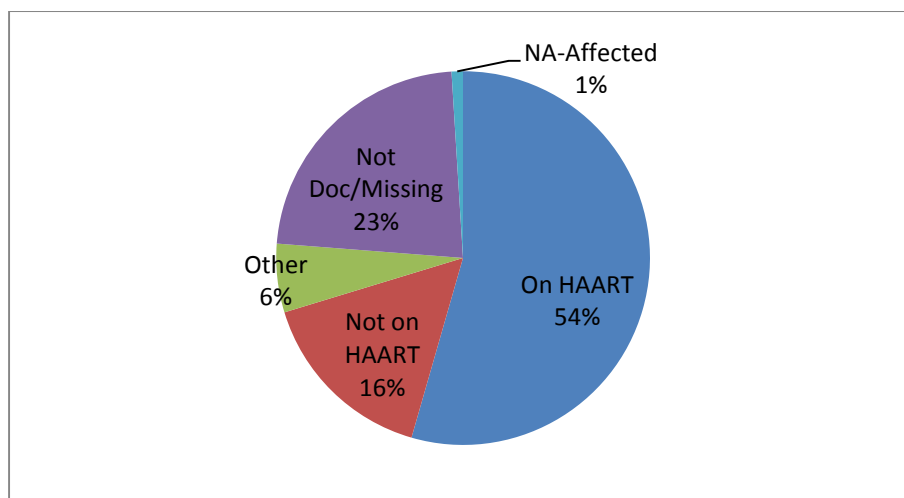
Risk category	# in total sample (%)	# with VL<50 (%)
White	27 (11%)	10 (37%)
Black	197 (81%)	72 (37%)
MSM	23 (10%)	5 (22%)
Heterosexual	72 (30%)	25 (35%)
IDU	53 (22%)	17 (32%)
Heterosexual & IDU	16 (7%)	7 (44%)
Male	111 (46%)	40 (36%)
Female	128 (53%)	50 (39%)

A total of **38%** of clients were found to have undetectable viral loads (<50 copies/ml). Table 2 above shows the number of clients with documented viral loads alongside those with undetectable viral loads in the same risk/age/gender categories.

TREATMENT STATUS

Treatment decreases morbidity and mortality in persons with HIV/AIDS and greatly reduces the risk of transmission. Over half of the charts reviewed documented treatment with HAART (**54%**), while **16%** of charts noted that clients were not on HAART (*Figure 11*). Treatment status was missing in **23%** of charts reviewed. An additional **6%** of clients were not on HAART as they were in palliative care.

Figure 11: Treatment status for psychosocial clients (N=242)

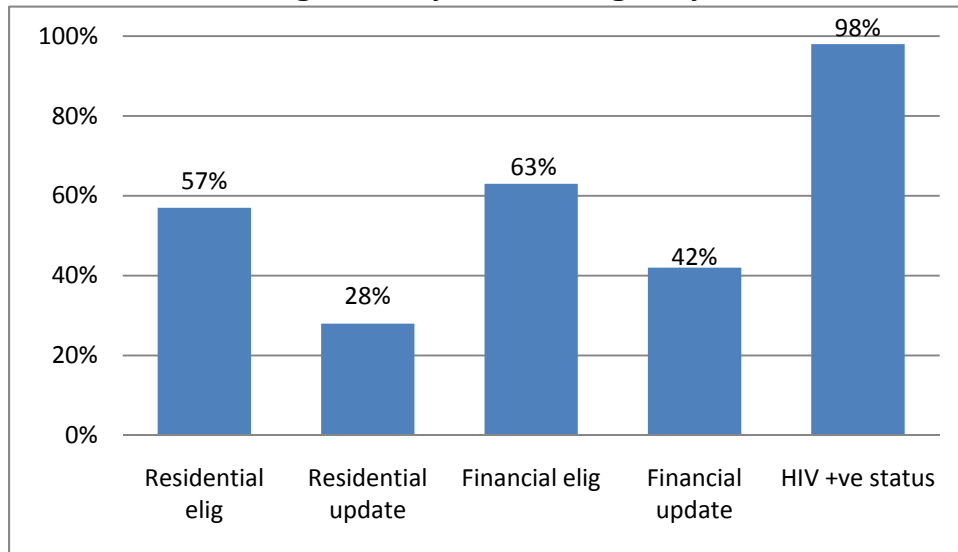


RYAN WHITE ELIGIBILITY

As part of the baseline evaluation, agencies are required to establish eligibility for Ryan White services. They are to document proof of HIV status, that the client resides in the EMA and their

income is no more than **300%** of the federal poverty level. Residential eligibility was documented in **57%** of charts reviewed with only **28%** of those updated during the fiscal year. Similarly, **63%** of charts had documentation of financial eligibility, while **42%** of those were updated. Nearly all (**98%**) clients had proof of HIV status available in the chart. An additional **1%** were affected caregivers and thus proof of HIV status did not apply, while **1%** of charts lacked any documentation on HIV status, *Figure 12*.

Figure 12: Ryan White Eligibility

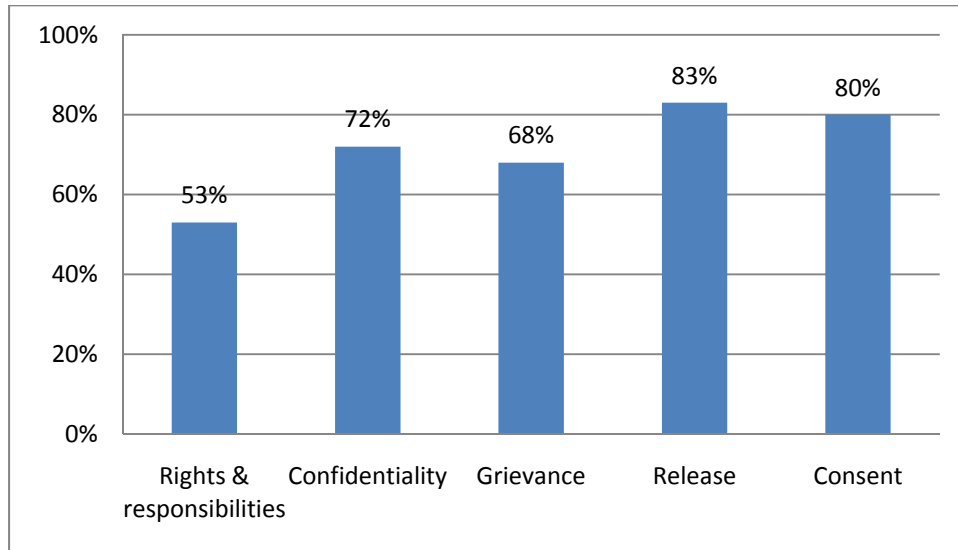


CLIENT RIGHTS AND POLICIES DOCUMENTATION

Agencies are required to provide documentation that the client has been provided with certain items regarding client rights and confidentiality. The agency must retain signed copies of those policies, indicating that the documents have been received and explained.

The highest compliance was found with the release of information and consent to receive services forms, which were both documented in over **80%** of charts. The process by which clients might file a grievance form was documented in **68%** of charts, while the confidentiality policy was found in **72%** of charts reviewed. Statement of patient’s rights and responsibilities had the lowest compliance as it was only documented in **53%** of charts reviewed, *Figure 13*.

Figure 13: Documentation of Clients' Rights and Policies



SECTION 4. CLIENT CHART ABSTRACTIONS

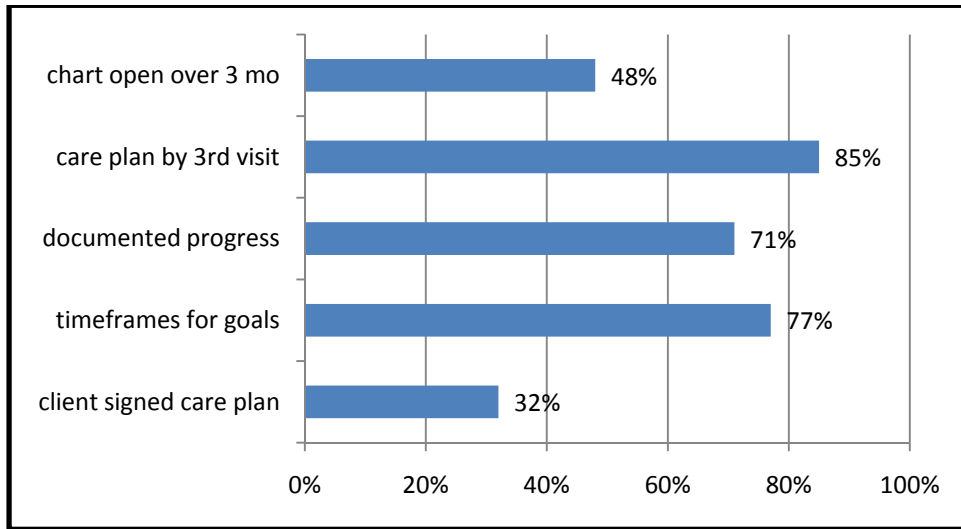
According to the Psychosocial Standards of Care, services must begin with an initial evaluation which can be an intake or psychosocial assessment. After the assessment, a plan should be developed and agreed upon by the client and agency, which outlines goals and services that will be provided to meet these objectives.

INTAKE/ASSESSMENT

Of the **242** client charts reviewed, **198 (82%)** had a documented intake. Of the **198** charts with a documented intake/assessment, **83%** had a documented need for psychosocial services and **58%** had documented mutual goal setting as part of the intake/assessment process.

Of all the charts reviewed, **112 (46%)** had a care plan developed and agreed upon by the client and agency (*Figure 14*). The care plans outlined service goals and services to be provided to meet the objectives based on the intake/assessment. We observed that a third of the care plans were signed by the clients (**32%**), while a larger proportion (**77%**) had timeframes for delivery of services. Furthermore, **71%** of charts with plans had documentation of the client's progress toward meeting established goals as stated in the care plan. Most of the care plans (**85%**) were entered in the client chart by the third client visit after services began. Of the charts with a care plan, **71%** of them had been open over three months and of those, **48%** had been updated.

Figure 14: Completeness of care plans, n=112



Of all the charts reviewed, **79%** had documentation of discussions with clients of services offered by the agencies, as well as the client's needs and determination of appropriate psychosocial support services.

A total of **42 charts (17%)** did not document any counseling services as appropriate for the client. The rest of the charts documented at least one type of counseling service to be appropriate in the intake/assessment; with individual counseling (**34%**), group (**33%**), substance abuse counseling (**20%**) and transition counseling (**15%**) being the most common services indicated. *Table 3* below summarizes which services were indicated and which ones were actually provided to the clients after intake. When looking to see which of these services were actually provided to the clients, individual counseling (**54%**), group counseling (**54%**), transition counseling (**16%**) and pastoral counseling (**9%**) were the most frequently documented services. Other less frequently provided services included child abuse/neglect counseling, nutritional counseling, bereavement counseling, caregiver counseling, drop-in counseling, recreational counseling, peer counseling and benefits counseling. Other needs identified and provided in addition to psychosocial support included housing, furniture, medical, food, transportation, vocational, and educational services.

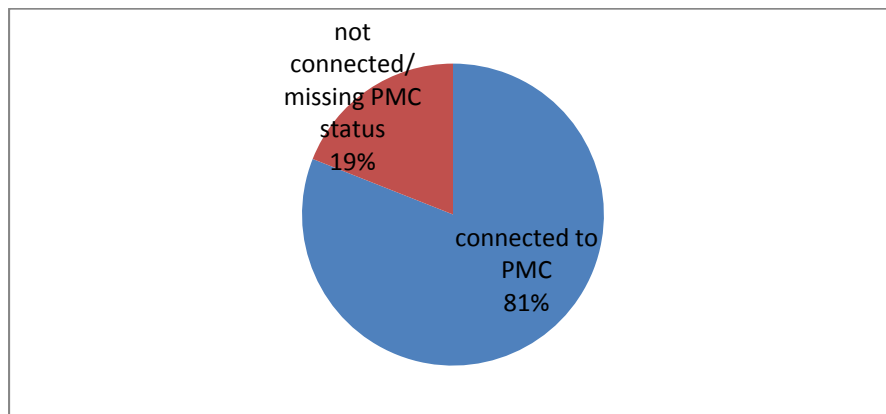
Table 3: Summary of services indicated and services provided to psychosocial clients

Type of counseling (n=204)	Indicated services	Services provided
Individual counseling	34%	54%
Group counseling	33%	54%
Transition counseling	15%	16%
Pastoral counseling	7%	9%
End of life planning	4%	3%
Recreational counseling	--	7%
Bereavement counseling	7%	4%
Drop-in counseling	1%	3%
Caregiver counseling	2%	3%
Benefits counseling	3%	2%
Child abuse/ neglect counseling	1%	1%
Benefits counseling	3%	2%
Substance abuse	20%	1%
Family reunification	0.4%	1%
Art Therapy	1%	3%
Nutritional Counseling	6%	2%
Peer counseling	4%	1%
HIV prevention	1%	1%

There was documentation of **69 clients (29%)** needing other services not provided by the agency. Of those, **48 clients (70%)** were referred for those other services and follow-up to the referrals was documented in almost half of the charts (**48%**). The agency also provided feedback to the referring provider **22%** of the time. There was only **1 (100%)** chart that documented a plan to communicate regularly regarding a wait list status.

Excluding clients in palliative care and affected caregivers, **81%** of the charts we reviewed documented that the clients were connected to primary medical care. A total of **40 clients (19%)** were either not connected to primary care or linkage was missing from the chart, *Figure 15*.

Figure 15: Primary care status of psychosocial clients, n=212



FURTHER/CONTINUED SERVICES

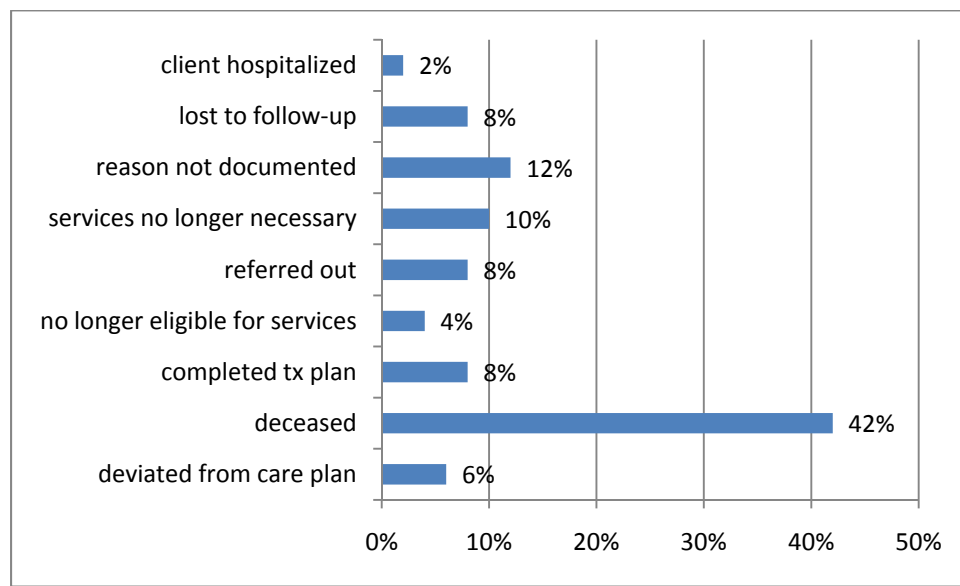
The standards of care require that programs show evidence of client progress toward meeting established client goals through documentation of activity. Such documentation was found in **85%** of charts reviewed. Counseling service units provided to the client were documented by: progress notes (**68%**); group notes (**15%**); service tracking forms (**26%**); copies of sign-in sheets (**10%**); client plans (**3%**) and team meeting minutes (**3%**).

In addition, there is also a requirement for counseling services to be monitored periodically (at least once every three months) to determine if the agency's service goals are being met, as well as a six-month reassessment of service needs. Of the charts open over 90 days, quarterly monitoring of psychosocial services was documented in **37%** of charts. Of the charts with quarterly monitoring, methods used to document the updates were: update of care/treatment plan (**7%**); progress notes documenting monitoring by the counselor (**90%**) and tracking forms (**6%**). Likewise, **178** charts were open over six-months and of those, **18** charts (**10%**) had a six-month reassessment of service needs.

TERMINATION

The length of time that psychosocial charts remained open ranged from **0** to **246** weeks, with the average being **26** weeks. A total of **59** charts showed that clients had been inactive for over **3** months and **50 (85%)** had documentation of services being terminated. Reasons for termination included: clients deviating from care plans (**6%**); clients deceased (**42%**); clients completed treatment plan (**8%**); clients no longer eligible for services (**4%**); clients referred out to other providers (**8%**); services were no longer necessary (**10%**); hospitalization (**2%**); lost to follow-up (**8%**) and reason not documented in **12%** of the charts reviewed (*Figure 16*). Upon termination, **12%** of clients were notified of the agency's policy regarding re-engagement with services.

Figure 16: Reason for termination of psychosocial services; N=50



SECTION 5: CONSUMER SURVEYS

Current psychosocial support clients at the reviewed agencies were asked to complete a survey to provide another method of assessment of the agencies compliance with the Standards of Care. Questions focused on services provided and the patient's knowledge of their care, as well as their satisfaction with services. A similar subset of questions was contained in each of the consumer surveys that were used for all reviewed service categories.

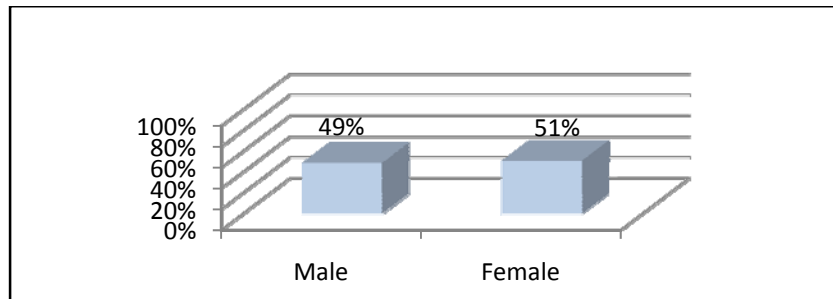
A total of forty-five (N=45) consumers participated in the consumer surveys, representing 8 agencies that are funded to provide Psychosocial Services in the Baltimore EMA. Consumer surveys were directly administered by CQM staff both in person and by telephone.

DEMOGRAPHICS

Gender

Female psychosocial support consumers slightly outnumbered males, (51%) and (49%) respectively [Figure 17].

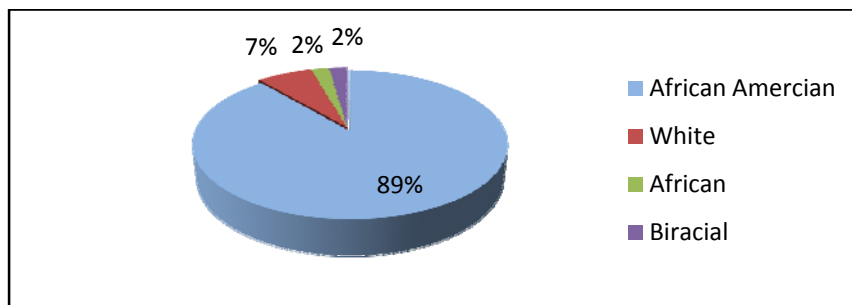
Figure 17: Gender distribution of consumers surveyed, N=45



Race

Eighty-nine percent of the respondents defined their race as African/American or Black, (7%) White, (2%) African and (2%) identified as biracial [Figure 18].

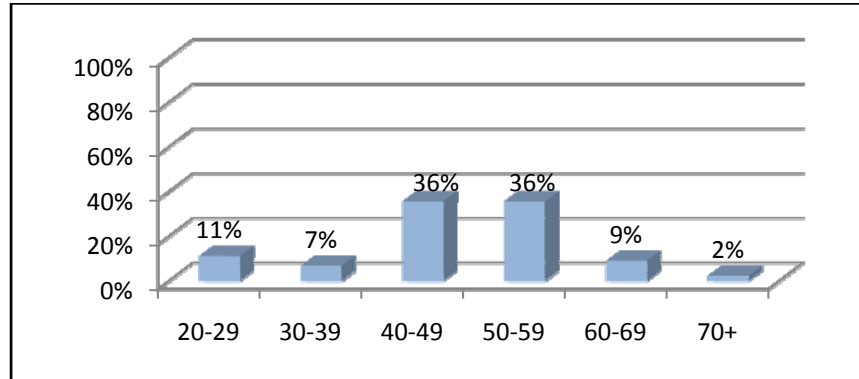
Figure 18: Race/ethnicity of consumers surveyed, N=45



Age

Of those surveyed, more than one third of (36%) consumers were aged 40-49, the same percentage (36%) were 50-59, another (11%) were 20-29, less than ten percent were 60-69 (9%). **Seven percent** of respondents were 30-39 and (2%) were in their seventies [Figure 19].

Figure 19: Age, N=45

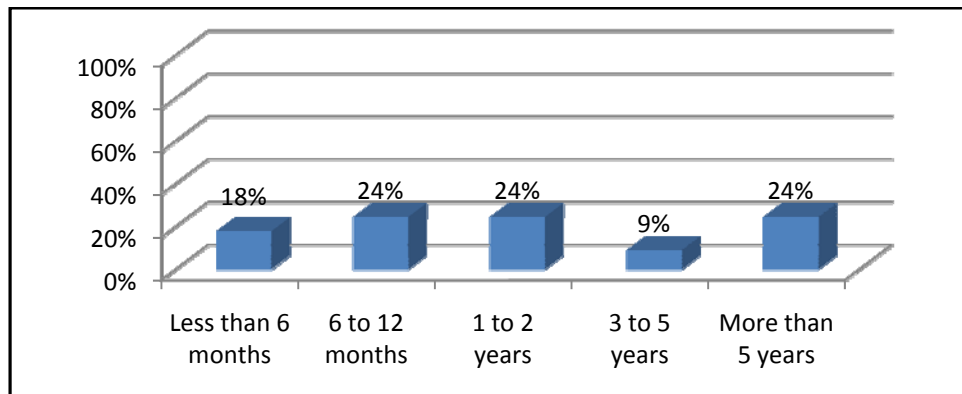


UTILIZATION OF PSYCHOSOCIAL SERVICES

Receipt of psychosocial services

Nearly one quarter (24%) reported engaging in psychosocial services more than five years. The same percentage reported using services for 6 to 12 months (24%) and 1-2 years (24%). **Eighteen percent** received services for less than 6 months and (9%) for 3 to 5 years [Figure 20].

Figure 20: Receipt of Services, N=45



Agency Policy

When asked, the majority of consumers recalled being given most agency related policies at their clinics. [Table 4]

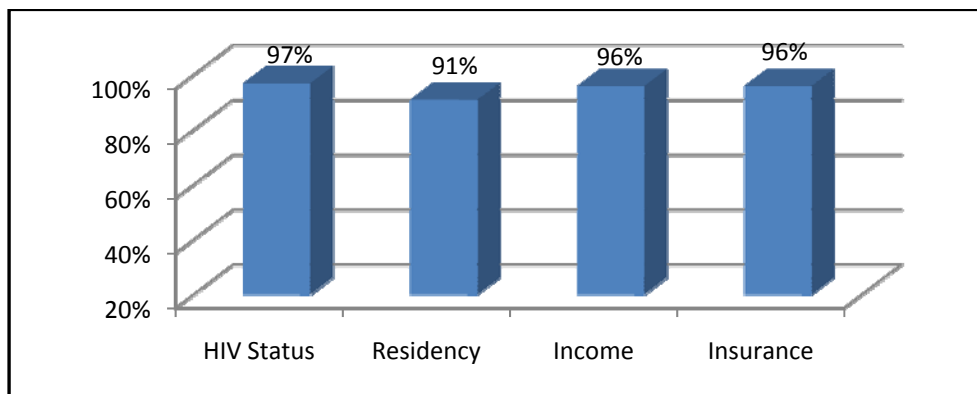
Table 4: Agency Policy Receipt, N=45

Agency Policy	Number	Percentage
Grievance Procedures	42	93%
Rights and Responsibilities	43	96%
HIPPA Confidentiality	44	98%
Release of Information	44	98%
Informed Consent	43	96%
List of RW services	15	33%
Fee Structure/Client charges	12	27%
Termination Policy	14	31%

Documentation of Program Eligibility

All Ryan White Part A clients must establish initial eligibility prior to the initiation of services. Consumers indicated that this information was requested at consistently high rates for HIV status (97%), residency (91%), income (96%) and insurance (96%) [Figure 21].

Figure 21: Documentation of Eligibility, N=45



Receipt of Agency Services

Consumers were asked which services they received at their respective agencies. Most received individual/group counseling (78%) or HIV support group services (71%). [Table 5]

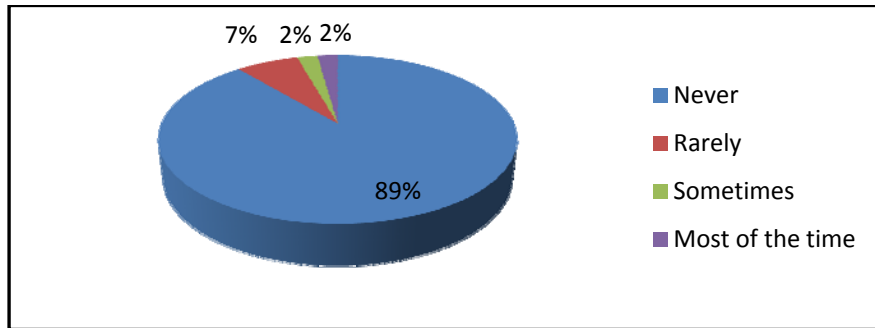
Table 5: Receipt of Services, N=45

Counseling Service	Number	Percentage
Individual/ Group Counseling	35	78%
HIV Support Group	32	71%
Peer Counseling	18	40%
Nutrition Counseling	16	36%
Pastoral Care	7	16%
Bereavement Counseling	3	7%
Caregiver Support	2	4%

Psychosocial counseling relationship

Communication between counselor and client was “Never” difficult for (89%) respondents [Figure 22]. Virtually all (98%) clients indicated that their counselor treated them with dignity and respect.

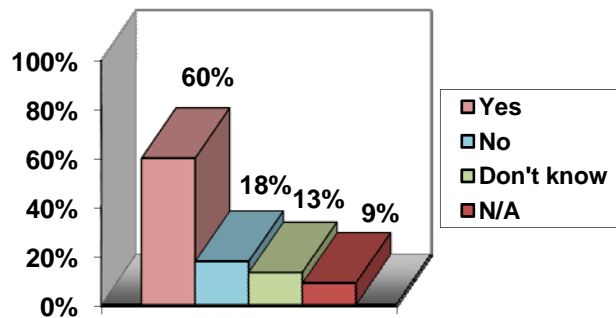
Figure 22: Counselor/ Client Communication, N=45



Psychosocial Care Planning

Sixty percent of respondents indicated they signed a treatment or care plan specifically focusing on psychosocial services, while (18%) did not sign a plan. The remaining clients either did not remember (13%) or indicated that the question was not applicable (9%), Figure 23.

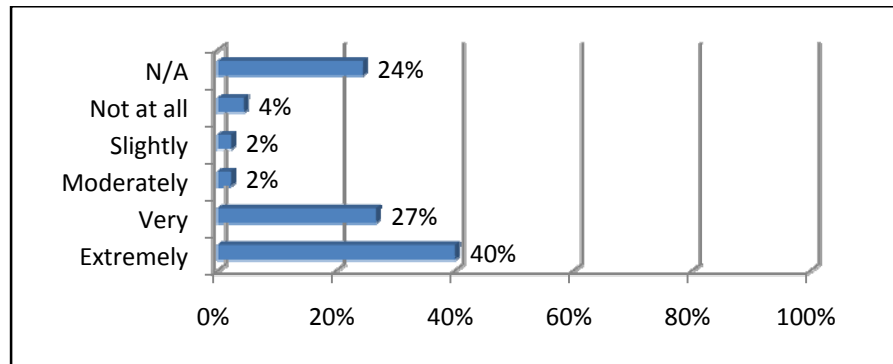
Figure 23: Consumers with signed care plans, N=45



Care Plan Development

The most frequent response was “Extremely” (40%) when consumers were asked about their involvement in developing a personalized care plan. [Figure 24]

Figure 24. Consumer care plan involvement, N=45



All (27) of the individuals with a treatment plan indicated the plan clearly stated the services to be received in addition to which problems or issues would be resolved.

Clinic Staff Accessibility

The majority of clients (87%) indicated that clinic staff were always available by phone after hours [Figure 25]. Virtually all (98%) “agreed” or “strongly agreed” it was easy to schedule appointments for convenient times. [Figure 26].

Figure 25: After Hours Accessibility, N=45

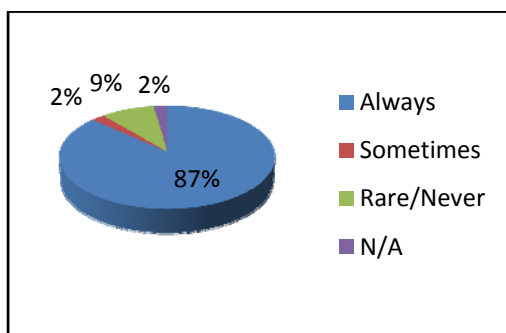
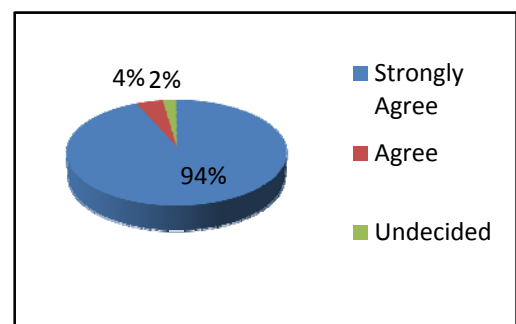
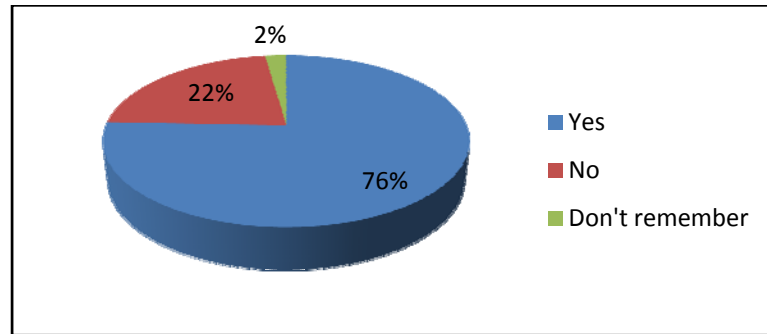


Figure 26: Appointment Scheduling, N=45



As illustrated in Figure 27, consumers were asked if they were given information about accessing the Consumer Advisory Board. Three quarters (76%) said “yes”, however (24%) said “no” or did not remember.

Figure 27: CAB, N=45



Client Satisfaction with Services

Consumers responded to questions regarding their satisfaction with the psychosocial services provided. Overall satisfaction with the quality of psychosocial support services was very high (94%). Additionally, nearly all clients expressed confidence that their personal information was sufficiently protected and confidential. **Ninety-three percent** indicated they would recommend their counselor to others with similar needs.

SECTION 6. QI ORGANIZATIONAL ASSESSMENT

All **eight** agencies completed a quality improvement organizational assessment. The **15** items covered the programs' quality structure, planning, performance measurement, improvement activities, staff involvement, consumer involvement, evaluation, and information systems. The survey was administered by CQM staff and agencies were asked to score themselves on a scale from 0-5 where 0 was the lowest score and 5 the highest. Agencies were asked to provide an explanation of each ranking and, where backup documentation was available, it was reviewed. Each question is presented along with the average score. *Figures 28A & 28 B* show the average scores per item across psychosocial programs.

SECTION A. QUALITY STRUCTURE

1. Does the HIV program have an organizational structure to assess and improve the quality of care? – Average score **3.6**. Overall, most agencies had regular quarterly meetings attended by clinicians and multidisciplinary representation who were involved in the process.
2. Were appropriate resources committed to support the HIV quality program? – Average score **2.9**. Most agencies reported that resources were scarce for the quality program and responsibilities were mostly on one person as opposed to the whole team.
3. Did the HIV leadership support the HIV quality program? – Average score **3.9**. Most agencies report that HIV program leadership set quality priorities and established a commitment to quality.
4. Does the HIV quality program have a comprehensive quality plan? – Average score **3.4**. Written quality management plans existed at most agencies. Plans were updated annually, but all staff members were not involved in the plan's development or update.

SECTION B. QUALITY PLANNING

1. Were annual goals established for the HIV quality program? – Average score **3.5**. Annual goals are discussed by the HIV quality committee and were based on past performance and external requirements. However, quality goals were not always communicated to all staff nor were all staff involved in the selection process for the goals.

2. Does the HIV program have clearly described roles and responsibilities for the HIV quality program? – Average score **3.0**. Many agencies report that key roles and responsibilities are described for the quality program. There is some staff involvement in the design of these roles and responsibilities.

3. Is there a document in place to specify timelines for the implementation of the HIV quality program? – Average score **2.6**. Agencies report that work plans and timelines are in place though they were not reviewed and updated regularly and rarely had timelines. Some staff are aware of the work plan.

SECTION C. QUALITY PERFORMANCE MEASUREMENT

1. Were appropriate quality indicators selected in the HIV quality program? – Average score **3.5**. Agencies selected indicators based on results of their quality initiatives and external audits and were reflective of the standards of care. Staff were not always involved in the development of the indicators.

2. Did the HIV program routinely measure the quality of care? – Average score **3.5**. Performance measurement was completed with the input of some staff, results were reviewed by a quality committee and action was taken on the results. The process of performance measurement was described to some extent and some staff had training on performance measurement methodologies.

SECTION D. QUALITY IMPROVEMENT ACTIVITIES

1. Did the HIV program conduct quality projects to improve the quality of care? – Average score **3.3**. Quality improvement activities focused on processes and projects were based on data. Findings were submitted to the quality committee and at least one data-driven quality improvement project was completed.

2. Was a team approach utilized to improve specific quality aspects? – Average score **3.3**. Team approaches were common among agencies surveyed. All staff had a basic knowledge about the QI team approach, but did not necessarily use methodologies such as PDSAs and root-cause analyses. Team approaches were used to identify and address quality issues.

SECTION E. STAFF INVOLVEMENT

1. Does the HIV program routinely engage staff in quality program activities? – Average score **3.6**. Nearly all staff members are involved in quality activities, some may attend annual quality trainings, and some participate in quality projects. Some staff members are knowledgeable about quality principles and may participate in identifying priorities and goals for the quality program.

SECTION F. CONSUMER INVOLVEMENT

1. Are consumers involved in quality related activities? – Average score **3.6**. Agencies report that patient needs are assessed and discussed in quality meetings. Some agencies report incorporating consumer feedback in setting quality goals. Results of quality activities are not always shared with consumers.

SECTION G. EVALUATION OF QUALITY PROGRAM

1. Is a process in place to evaluate the HIV quality program? – Average score **2.9**. Review of ongoing quality activities was done if necessary. Some results from evaluations are used to plan ahead for future quality efforts, but not in a comprehensive way.

SECTION H. CLINICAL INFORMATION SYSTEMS

1. Does the HIV program have an information system in place to track patient care and measure quality? – Average score **3.8**. Most agencies report having a functional information system to track patient care and produce reports. Some of the data collected are used for quality activities.

Figure 28A. Average Scores on Elements of the Organizational Assessments

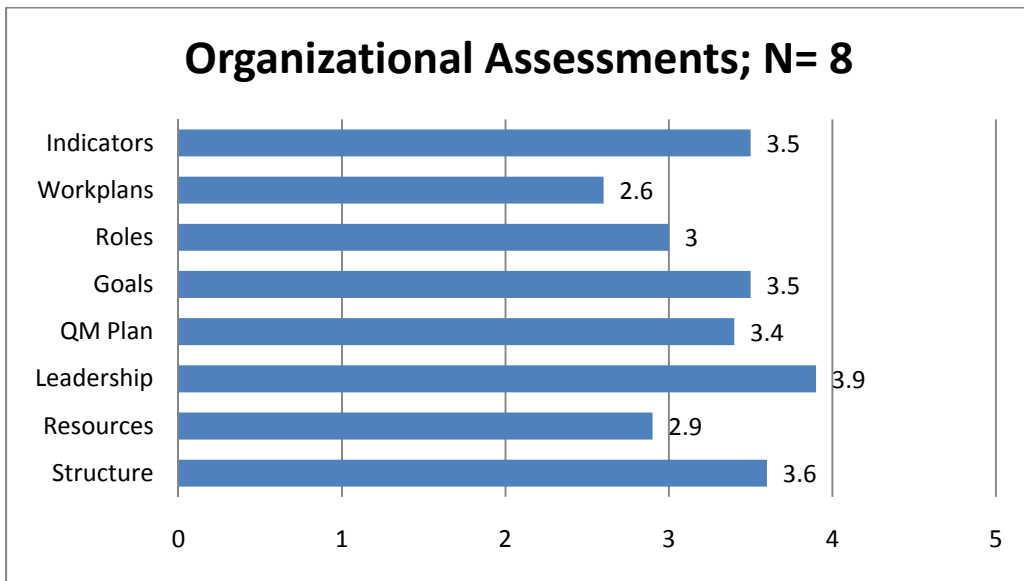
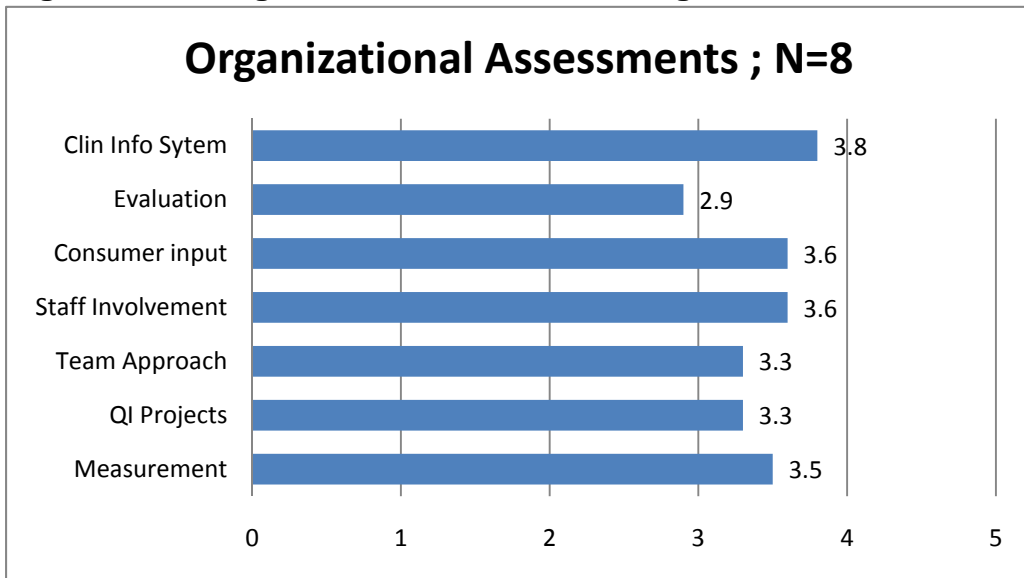


Figure 28B. Average Scores on Elements of the Organizational Assessments



SECTION 7: SUMMARY OF FINDINGS

The CQM process provided a systematic review of compliance to the EMA's Standards of Care for all psychosocial vendors receiving Part A funds during FY2010. A total of **242** psychosocial charts were reviewed, representing **43%** of Part A Psychosocial support clients within the Baltimore EMA. In most cases, many of the standards were consistently met with a few exceptions. The following are specific strengths and areas for improvement derived from the chart abstractions, organizational assessments and consumer surveys:

Strengths

- Demographics: Agencies did a great job of capturing the client's age, gender, race and residence.
- Risk factor and insurance status were also documented at high rates.
- Documentation of HIV status for purposes of determining eligibility was **98%**.
- **83%** of charts had an intake/assessment. Of the clients who had an assessment, **85%** of those had care plans entered in their charts by the third visit.
- Of the required agency policies, consent to release patient's information and consent to participate in the program were documented at **83%** and **80%** respectively.
- Agencies had high scores in their organizational assessments in quality structure, planning, performance measurement, staff and consumer involvement, and use of clinical information systems to measure quality.
- Almost all consumers reported being treated with dignity and respect, everyone reported satisfaction with the services they received, and **93%** reported they would recommend their psychosocial counselor to others with similar needs.

Areas for Improvement

- Although HIV status was well documented, residential and financial eligibility were only documented in **57%** and **63%** of charts respectively. Though a six-month update was required, the financial and residency update rates of documentation were even lower at **42%** and **28%** respectively.
- **19%** of charts were missing documentation of primary care enrolment.
- Documentation of Client Rights and Responsibilities was only **53%**.
- Only one-third of the care plans were signed by clients.
- Of the **193** charts open over 90 days, quarterly monitoring of psychosocial services was documented in **37%** of charts. Likewise, **178** charts were open over six-months and of those, **18** charts (**10%**) had a six-month reassessment of service needs.
- In regards to the HIV quality program, most agencies reported low resources for their quality activities and responsibilities mostly fell on one person as opposed to a team effort.

SECTION 8: DISCUSSION AND RECOMMENDATIONS

The charts revealed a variety of psychosocial services were offered to clients in the EMA with the most common being group and individual counseling. Other less common services included bereavement counseling, end of life planning, recreational counseling and transition counseling. Clients requiring services not typically provided under psychosocial support were referred out to other agencies most of the time.

Providers should seek to identify clients who are not currently engaged in primary care and refer them as necessary. This is crucial as treatment not only leads to improved patient outcomes but also reduces subsequent HIV transmission. Documentation of this can be increased by simply noting the patient's primary care provider and their last appointment date.

Agencies did well to ensure that care plans were completed after intake into the program. However the care plans were rarely signed by the clients, lacked mutual goal setting, timeframes for accomplishing service goals, were not always monitored quarterly, or reassessed every six-months. Psychosocial providers should devise a strategy to ensure care plans are reviewed quarterly and noted in the client's chart.

Documentation of Ryan White eligibility and subsequent six-month updates continue to be poor. Providers should strive to have this documentation in the charts before commencement of services whenever possible. Failure of clients to provide requested items should be clearly noted in the chart.

Agencies have also significantly improved their quality management programs. With the exception of a few areas, most vendors scored at or above average in most of the quality components outlined in the organizational assessment. Agencies should continue to work on improving the infrastructure of quality programs as that often supports improved patient outcomes.

Consumers were almost universally satisfied with the psychosocial services they received. They report receiving most agency policies, show continued engagement and receipt of services, report access to staff even off hours, and are able to make appointments at times that meet their needs. Many clients do not have a care plan in place for services and some did not have access to a consumer advisory board.

The average length of time that psychosocial charts were open was six-months. There were a small number of charts that have remained open for many years and have not necessarily had reassessments to show that psychosocial support was still appropriate or necessary. There were a few charts that were inactive for over three-months, but had no documentation of termination. Agencies should ensure they have a process in place to review and close out inactive charts.

SECTION 9. ACKNOWLEDGMENTS

Funding for the Clinical Quality Management Program at the Baltimore City Health Department is made possible by the Ryan White HIV/AIDS Treatment Extension Act of 2009 administered by the Health Resources and Services Administration under the Department of Health and Human Services. Thank-you to the Clinical Quality Management staff including Iris Allen, MPH; Evelyn Bradley, DrPh; Hilda Ndirangu, MS; Tracy Olivier, MS; Christy Skipper, BS; and Jesse Ungard, MA; as well as members of the administrative team, the Greater Baltimore HIV Health Services Planning Council, Carolyn Massey, Chair; additional partners including InterGroup Services, Inc.; Associated Black Charities, Inc.; The Taylor-Wilks Group, Ltd.; Training Resources Network, inc.; and the Pennsylvania/MidAtlantic AIDS Education and Training Center, Johns Hopkins Local Performance Site. Finally, a special thanks to the Baltimore service providers and consumers, without whom this work would not be possible.

APPENDIX

Appendix A. Psychosocial Support Service Standards of Care available at:
<http://balpc.intergroupinfo.com/doc/doc/24/Psychosocialstandards2010.pdf>